

PERCEPTIONS OF CARING AND NURSING BY SENIOR LEVEL BACCALAUREATE
NURSING STUDENTS FROM THAILAND AND THE UNITED STATES AS INFLUENCED
BY CURRICULUM FOCUS: A DESCRIPTIVE, COMPARATIVE STUDY

BY

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CONNIE STOPPER

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Helen R. Connors, PhD, RN, FAAN

Sue A. Popkess-Vawter, PhD, RN
Chairperson/s

Committee members' Wanda Bonnel, PhD, RN

Ratchneewan Ross, PhD, RN

Lisa Stehno-Bittel, PT, PhD

Carla Sabus, PT, PhD

John Nelson, PhDc, MSN, RN

Date defended: August 22, 2012

The Dissertation Committee for MARY CONSTANCE STOPPER certifies that this is the approved version of the following dissertation:

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Co-Chairperson Helen Connors

Co-Chairperson Sue Popkess-Vawter

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ABSTRACT

The health care delivery system and its services are experiencing significant changes that affect nursing's core concept of caring. These changes are often complicated, influenced by the context of a particular environment, and are comprised of specific purposes and agendas aimed at meeting the healthcare needs of the consumer. Healthcare organizations are structures through which individuals cooperate systematically to conduct business. Business like as it may sound, "within the walls of the health care organization in all settings, profound human experiences happen every single day" (Koloroutis, 2004, p. 7) that strike to the essence of nursing, that of caring. Challenges unique to nursing must be addressed in this changing environment. It is appropriate, therefore, that the essential characteristic of caring within the profession of nursing and within all cultures be a focus of study.

Nursing faculty have as their role to develop and implement curriculums that contribute to the development of the skills needed to prepare graduates for practice in an increasingly complex healthcare environment while still fostering the professional socialization of students into the values, principles, and beliefs of the profession. Evaluation of the effects of the curriculum in preparing students to practice in an environment aimed at healing and caring is encompassed within this role. In the process of curriculum change aimed at meeting societal health care needs, faculty continues to be challenged to monitor for gaps in the overall curriculum. In meeting the challenges for the future, curriculum models are being developed and implemented based on caring science. This study compared nursing schools that have incorporated a caring model curriculum with a systems model curriculum. Students from three schools in the Southeast or Midwest United States, and Thailand participated in the study. Senior level and entry level students provided their perceptions of caring using the Caring Factor Survey

– Care Provider Version (CFS-CPV) and the Caring Factor Survey – Care for Self (CFS-CS) instruments. Demographic information was also collected. There were no statistically significant differences between schools having a caring curriculum model and a systems model. Significant positive correlations were found for CFS-Care Provider and Care for Self total scores; that is, those students who scored higher on the care provider instrument also scored higher on the care for self-instrument. Entry level students in Thailand scored higher than seniors from the Southeast and Midwest schools on the CFS-Care Provider and Care for Self instrument. Qualitative themes related to reasons motivating answering of the questions included: positive attitude or respect toward self-care, personal attributes, current intervening factors that decrease the ability to care for self, external factors contributing to self-care such as family, friends, and life experience, influence of faith, religion, and spirituality, personal philosophical statements, and lifestyle. While there was variability in the demographics, these did not have statistical significance on the study.

The outcomes of the study have generated further questions for research and confirm the importance of focused study on the development of curricula, creation of courses consistent with the curriculum, implementation of learning strategies, and evaluation of outcomes in meeting the goal of sustaining nursing's value of caring as it relates to health of individuals and populations and across cultures.

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CHAPTER 1

INTRODUCTION

Few have argued that caring is a concept with multi-faceted dimensions or that it is an essential component in developing interpersonal relationships necessary to the provision of patient-centered, safe, quality healthcare in nursing. While the literature is replete with articles on the concept of caring, there has been little research about the factors influencing its incorporation within nursing practice settings or how nursing students learn the meaning of the concept and how to apply it in practice.

Interest in the concept of caring for this study was first derived from observation of nurse-patient interactions in the clinical setting and inquiry about the role of environmental factors in supporting a caring process. Observation also generated an interest in the preparedness of the new graduate to enter a health care arena where quality assurance and patient satisfaction are assessed regularly and where new models for the organization of care are being implemented that overtly recognize the value of relationship and caring in nursing. Subsequent questions about new nurse graduate transition into the health care employment setting and its culture as well as to caring models of practice provided direction for focusing specifically on the effects of the nursing curriculum in preparing students to form and maintain caring relationships characteristic of the goals of the profession. Curiosity was also generated about cultural similarities or differences that might exist in nursing schools outside of the U.S., specifically in Thailand where the writer had been engaged in other research study.

The purpose of this study was: 1) to explore undergraduate nursing student perceptions of caring to determine if those students educated in a nursing curriculum that has caring theory incorporated as a primary focus within the curriculum framework differ from those students

educated in a nursing curriculum that uses a more traditional general systems theory approach in the curriculum framework; 2) to investigate if there are differences in perceptions of caring by baccalaureate nursing students from schools with a caring framework in the U.S. and, schools in Thailand.

Watson's (2008) theory of Human Caring grounded in the philosophy and science of caring in nursing formed the conceptual framework for viewing the concept of care. Drawing from Watson's definition of nursing, care within the context of the nurse and patient relationship; and, care of self as a prerequisite for establishing caring and healing relationships was examined. Student perceptions of caring in these two realms were used to compare schools of nursing incorporating a caring model in the curriculum and schools incorporating a systems model. Based on Leininger's (1988) approach to care as a universal concept, perceptions of caring were examined from students in two different countries, the U.S. and Thailand (McFarland, 2006).

Chapter 1 provides an introduction to the background and factors leading to investigation of the concept of caring within nursing curriculums as reflected in the perceptions of caring of baccalaureate nursing students. The purpose of the study, specific research questions guiding the study, and the significance of the investigation are described. Additional information is included delineating the conceptual framework for the study and elucidating study terminology as well as identifying assumptions and limitations of the investigation.

Factors Influencing Caring Nurse-Patient Relationships

There are a wide variety of factors in healthcare today leading to a de-emphasizing of caring as core in nurse patient relationships that are healing. These factors relate to transformational changes in health care delivery occurring, in part, as a response to health care reform. One factor is that the health care delivery system, internationally, is and will continue to be in the midst of

transformational changes that pose challenges to the culture and climate of nursing as well as other disciplines. A second factor relates to the challenges in the development of healing and caring relationships posed by a changing climate within the delivery system. Caring is central to the practice of nursing and is a key concept in the building of healing relationships. The changing culture of the health care delivery system and the climate in which nursing is practiced poses barriers to the expression of the value of caring. A third factor is that nursing education, essential in the preparation of practitioners who will maintain the values of the profession, also faces challenges to the teaching of the value of caring in interpersonal relationships.

Culture and Climate of Health Care Delivery and Its Impact on Nursing

Change in the health care delivery system.

The health care delivery system's structure and processes provide the culture and climate for the development and support of caring and healing relationships. Transformational change has been occurring in the healthcare delivery system internationally in response to pressures for health care reform. Transformational change refers to changing the ways in which those "in the organization perceive their roles, responsibilities, and relationships" (Henderson, 2002, p. 189). The change is characterized by a process that results in a new state, not merely an improvement or extension of what is. The basic elements of the organization's culture, including norms, values and assumptions for functioning are altered, and the elements of the culture of the organization are reshaped (Henderson, 2002).

Healthcare organizations today are complex structures, influenced by the context of a particular environment, and comprised of purposes and agendas aimed at meeting consumer healthcare needs from a holistic perspective. They have and continue to develop as highly organized systems. Hospitals have been a primary provider of health care services

internationally. They have been viewed traditionally as mechanistic: stable, predictable, systems that have clear cause and effect responses. They have been driven by a strong hierarchical leadership, directive relationships, minimal change and lack of attention to interdependence. Departments and disciplines have been organized and functioned under this model. Nursing within the healthcare institution has followed a similar pattern. The approach provided a strong degree of control over its care providers, nursing care, and other services provided to the public.

The growing complexity of healthcare delivery systems and other complicated societal, economic, and political pressures, however, are providing the driving force for looking at new ways to effectively address the health care challenges of today. From a transformation perspective, health care organizations are being viewed as complex adaptive systems. In complex adaptive systems, control and decision making are decentralized and highly dispersed at all levels of the system. The system is in continual change and adaptation is an on-going process. As a result of continual change and adaptation, that include decreasing centralized and hierarchical structures replaced by more autonomous and decentralized structures, behavior at the various levels in the hierarchy is less clearly known and often unpredictable.

Integral to institutional transformation, is change in culture and climate. The Kennedy Group (2011) identified that culture is comprised of values, beliefs, myths, traditions and norms. Through complex interactions, these entities develop over time. The pattern that has emerged in regard to health care is that it is considered a business in today's society and is driven by the values and principles of business. Underlying the rapid and continual change of healthcare systems is an emphasis on survival with lean performance, efficiency, and safe, quality outcomes. An example is the shortened hospital stays in acute care and the rise of a wide variety of community based, interdisciplinary care services that have been developed to meet healthcare

needs traditionally provided in the hospital setting. Within acute care settings, there is a movement away from restructuring of hierarchical models, toward formation of models of care that are unit-based and require fiscal responsibility and accountability, attention to culture and climate, and evaluation of work processes. Climate provides a measure of the dimensions of the work environment: that is, how the organization is structured; the type of leadership that is operational; operative historical influences; the vision and mission of the organization; the nature of the policies and procedures; standards of behavior and accountability; and affiliative characteristics such as trust, commitment, communication, rewards given, and connectiveness (Kennedy Group, 2011).

National and international efforts toward transformational change aim at changing both the culture and the climate of healthcare delivery so that patient centered care and patient satisfaction is primary. An example is the emphasis on continual assessment for quality assurance through the use of the Hospital Consumer Assessment of Health Plans Survey (HCAHPS) that was developed by the Centers for Medicare and Medicaid (CMS) and the Agency for Healthcare Research and Quality (AHRQ). HCAHPS is an evaluation of the satisfaction of patients related to all aspects of care including the nurse patient relationship. Oftentimes a primary motivator in such changes is the survival of the delivery system since financial incentives are often tied to outcomes from such surveys.

There is a reciprocal relationship between culture and climate with both subject to significant change during transformation that affects all aspects of the organization, including nursing and its services. Careful attention to the climate in which professional values have been expressed is critical at this time of change. Olson and Eoyang (2001) have identified that

responding to environmental factors, such as those currently confronting nursing will provide the measurement of value for the future.

Change within nursing.

The environment of health care services has been undergoing rapid change. Healthcare Reform has impacted healthcare delivery systems globally. The resultant changes are having a major impact on nursing. The International Council of Nurses (ICN) pointed to the relevance of health system reform to nursing as being significant. The Council has addressed the efforts of countries to improve health status of populations within the constraints of available health care resources (ICN, 2010). While the environment of change provides opportunities for nursing's continuing development as a discipline and profession, the long standing business approach of healthcare delivery poses significant challenges; particularly, for nurses focusing on building and maintaining caring and healing processes. Nurses must meet the expectations inherent in a business organization, and, the expectations of a discipline and profession characterized by caring. Thomas (1998) referred to these challenges when she addressed the corporatization of health services and its devastating effects; some that are reflected in the disconnection between a business culture and a caring culture. Watson (2006) articulated that "dominant institutional values and commitments are informed and guided by economics, technology, medical science and administrative theory" (p. 87). She further emphasized that the major focus is not on "what it means to be human, to be vulnerable, to be ill, to be cured, to be cared for, to be healthy, and to be healed" (Watson, 2006, p. 87). Watson's theory of caring has an "underlying value system based on a deep respect for life and caring as the moral ideal of nursing" (Baldursdottir & Jonsdottir, 2002, p. 68). This value system is believed to be essential for the practice of nursing and the healing process of patients.

The business orientation to which Watson (2006) referred has been developing since the publishing of *An Abstract for Action*, also known as the *Lysaught Report* (1970). In this report, there are complaints of an overemphasizing of the “expressive, emotional, nurturing side of nursing, which at the time was dismissed as a feminine trait instead of being understood as facets of deep knowledge and complex skills” (Benner, Sutphen, Leonard & Day, 2010, p. 23). The options at the time of the *Lysaught Report* were for nurses to be represented as “skillful in science and technology or as non-skilled nurturers – two mutually exclusive options” (Benner, Sutphen, Leonard & Day, 2010, p. 24). Years of effort to develop nursing from the perspective of the scientist has negatively impacted widespread focus on caring as a healing process within relationships.

The climate of nursing is characterized by the often found conflict between the business of healthcare and the professional values of nursing; yet, nursing is a significant player within an inter-disciplinary healthcare workforce. Internationally, there are more than 13 million nurses (ICN, 2011b). The two countries from which the sample for this study has been drawn employ large numbers of nurses in the provision of health care. Nursing in the U.S. is the largest healthcare occupation, with registered nurses having held about 2.6 million jobs in 2008. Hospitals employed the majority of RNs; 60 percent of such jobs. Approximately 8 percent of jobs were in offices of physicians, 5 percent in home healthcare services, 5 percent in nursing care facilities, and 3 percent in employment service with the remainder employed primarily in government or social assistance agencies or in educational services (United States Department of Labor, 2010). Statistics from the Thailand Nursing and Midwifery Council (TNC, 2010) indicate that in Thailand there were 145,353 RN’s in 2008, with the majority employed in hospital settings.

During this time of transformational change, nursing, as a primary care provider, is being challenged to examine its culture and inherent professional role, values and approaches in the provision of safe, quality care within a rapidly changing healthcare delivery system. Identifying methods for safeguarding the values and principles of nursing in the provision of care within a business oriented health care delivery system is essential to meeting desired safe, quality care outcomes. Careful attention to the climate in which professional values have been expressed is critical at this time of change. An eye to the impact of transformational change on the central value of caring and healing relationships in nursing is essential.

Challenges to Effecting Caring and Healing Relationships

Caring within the concept of relationship is a core value firmly rooted in nursing's culture as evidenced and promulgated in its history and in the guiding documents of the profession including: The ICN Code of Ethics (ICN, 2006), the ANA Code of Ethics (ANA, 2001), the ANA Social Policy Statement (ANA, 2010), the Nursing Scope and Standards of Practice (ANA, 2010), and others. In addition, the American Association of Colleges of Nursing has identified caring as key in the education of persons to the profession (AACN, 2008). It is significant that the most revised code of ethics for nursing (ANA, 2001) broadened the scope of the code to include all professional relationships and emphasized practicing with respect (Taylor, 2010). The International Code of Ethics (ICN, 2006) supported similar values and supported nurse's refusal to participate in activities that conflict with caring and healing.

Nursing, however, is being confronted with its own challenges to effectiveness in fulfilling its social contract; one that encompasses caring as a core concept in its practice. The challenges are closely related to the complex changes in society and healthcare delivery. The American Association of Colleges of Nursing (AACN, 2002) has addressed factors that are often

negatively impacting the work environment of contemporary nurses. These include “rapid advances in biomedical science, improved disease prevention and management, integration of new clinical care technologies, and shifts in care delivery to a broad array of clinical sites” (AACN, 2020, p. 1). These factors often serve as deterrents to the building of caring and healing relationships, and are integrally related to reorganization of delivery services, technologies in nursing, and workforce demographics.

Reorganization of healthcare delivery services.

Traditionally, nursing practice has focused most heavily on providing nursing services within the context of the acute care setting. Due in part to the financial burden resulting from the treatment of illness, health care reform is changing the focus of care from an illness or secondary care approach to a primary care approach focusing on health promotion, and prevention of illness. The focus is also on management of chronic illness and the minimization of complications. Healthcare services in this sector of the system are in a variety of non-acute care settings and are as business oriented as in the acute care setting. Most often these systems are managed by persons prepared with a business background.

While the setting itself does not negate incorporation of a caring approach in nursing, the business culture and its goals poses challenges for individual nurses working within these settings. The reforms aimed at health promotion and prevention necessitate new ways of conceptualizing nursing practice and the ways in which caring relationships are built and maintained within and across the changing system; characterized by shortened patient stays and exposure of patients to numerous professionals, each with their own focus of care. Hutson (2008) advised that the healthcare team in 2020 will be comprised of a multidisciplinary team of experts who are highly educated. While more highly educated providers with a variety of specializations

may have advantages, Gratton and Erickson (2007), in speaking of relationships, warn that the higher the proportion of experts on a team, the higher the likelihood for non-productive conflict.

Models of care today call for collaboration regarding the health and needs of patients.

Nurses increasingly find themselves as a part of healthcare teams comprised of professionals from a variety of disciplines working to address the needs of patients across the illness-wellness spectrum. Knowledge and skill in negotiating the relationships with other team members on behalf of establishing caring relationships with patients is important to the healing process.

Coordination of services for patients who are in transition between healthcare delivery systems is also increasingly within the role of the nurse (ANA, Scope and Standards, 2010). Nursing is confronted with changing conceptions not only of a single health care institution; it also needs to address its relationship to others across the system. This also has implications for changing leadership demands. Nurse administrators, in collaboration with health care institution administrators, are being challenged to lead change in the redesign of health care services and to develop and implement models of practice aimed at emphasizing the values of nursing that include caring and in achieving ever improving delivery of care. Nurse leaders are challenged in finding effective strategies for sustaining the core nursing value of building caring and healing relationships. The value of caring as a core concept must be firmly integrated within the practice role of each nurse who views him/herself as a leader in articulating the values of nursing.

Efforts aimed at meeting the challenges to the culture and climate of nursing posed by a health care delivery system in the process of transformational change are being made through such initiatives as development and implementation of models for practice grounded in caring values. One such interdisciplinary practice model being incorporated in healthcare settings and having caring as the theoretical model, is the Relationship Based Care Model (Koloroutis, 2004).

Incorporating caring models in practice assumes that the practitioner has been educated toward caring as an integral component of nursing practice. The challenge is that all too often nurses may not have been prepared to practice within this type of model.

Technologies and nursing.

Technology in all of its forms has the potential for contributing to improved care by enhancing the work environment for nurses. Concomitantly, increasing use of electronic and tele-health applications have the potential for altering the climate of nursing and distracting from the value of caring inherent in the nurse patient interaction. The world of technology, as we know it today, is new for the majority of the working population of nurses. Nursing is challenged to engage its members in integrating the tools of technology with the knowledge of nursing and the human interface in a way that enhances its relationships with patients and their families, other health care professionals, and each other. Moore and Visovsky (2000) advised that “a technologic-humanistic dualism does not have to exist in technology-mediated nursing care” (p. 2-629). Caring approaches need to be maintained within this technological environment.

Changing demographics in nursing.

There are changes within the profession related to the aging and retiring nurse workforce that are significantly impacting provision of nursing services and are forcing the profession to examine the nursing workforce as well as to focus on implications of changing demographics. A national sample survey found that the age of the working RN population in 2008 was 45.5 years and 16.2 percent were 50-54 years old, representing an aging trend that poses concerns for retirements in the near future (U.S. Dept. Health & Human Services, 2010b). In this same sample, it was found that within three years, 76,915 registered nurses over 55 years of age intend to leave the nursing profession and another 54,539 intend to leave their current position but are

unsure if they will remain in nursing. The findings of the national sample survey also revealed that 29.8 percent of RN's had already left their current position or planned to do so in the next three years (2010b). There are upwards to four generations of nurses with differing approaches to the practice of nursing. Loss of large numbers of veteran nurses who have served to socialize those new to the profession pose a threat to the preservation of the values of the profession, such as caring.

As indicated, the current nursing workforce includes a high proportion of nurses working in the later years of their careers, soon to retire. As a result of focused efforts to meet increasing health care needs for the future, there are also a high proportion of nurses at the onset of their careers. The demographics of today's acute care facility nurses reveal that 10 percent of the U.S. workforce is comprised of new nurse graduates. Midcareer nurses, the group most needed to fill the roles of those leaving the workforce, are the lowest in number (Committee on the RWJF, 2011). The Health Resources and Services Administration (HRSA, 2000) has projected an increased need for approximately 2.8 million full time RN positions in 2020; an 8 million position increase from that needed in 2000. If the projection needs are met, this will further increase the proportion of new grads to veteran nurses. Therefore, the knowledge, experience, and mentoring that senior nurses can provide could potentially be lost (Bleich, Cleary, Davis, Hatcher, Hewlett, & Hill, 2009).

In addition, there is a shortage of nurse educators to meet the demands for increased numbers of professional registered nurses. According to a *Special Survey on Vacant Faculty Positions* released by AACN in September 2010, a total of 880 faculty vacancies were identified in a survey of 556 nursing schools with baccalaureate and/or graduate programs across the country (70.3% response rate). In this same survey, it was determined that over 250 additional

faculty positions are currently needed to meet student demand. There is a 6.9% faculty vacancy rate and over 92% of these positions require or prefer the terminal degree (American Association of Colleges of Nursing, April, 2011).

The challenges discussed here provide a glimpse of the challenges to nursing in preserving the core value of caring in the midst of changing systems characterized by a highly business oriented culture and climate, an increasingly technological environment that has the potential for distracting from relationship building, and changing nursing demographics. These examples are by no means exhaustive; but, serve to illustrate the importance of leading change with an eye focused on the essential values upon which the profession of nursing is grounded, one of which is the concept of caring. ANA's (2010) statement on the scope of practice of nursing has addressed partnerships of the future that continue to "reflect the definition of nursing and illustrate the essential features of contemporary nursing practice" that includes "a caring relationship that facilitates health and healing" and "attention to the range of human experiences and responses to health, disease, and illness in the physical and social environments" (ANA, 2010, p. 29). One of the strongest partnerships being emphasized is that between nursing practice and education.

Challenges to Nursing Education

The nursing education system has as its primary role the socialization of those whose purposes aim at meeting the goals of the profession and discipline. There are legal and professional organizations globally that work toward providing guidance to practitioners, students and faculty in the education of students to the culture and climate of nursing. The American Association of Colleges of Nursing (AACN, 2008) has provided a national perspective for nursing education at the baccalaureate and higher education level. Their document, the

Essentials of Baccalaureate Education, provides a set of guidelines for the curricular elements and framework for baccalaureate education of the future. Several assumptions of the document include: that the baccalaureate graduate is prepared to “practice from a holistic, caring framework”; “engage in care of self in order to care for others”; “care for patients across the lifespan;” “care for patients across the health-illness continuum”; and, “care for diverse populations” (AACN, 2008, p. 9). The value of caring is explicitly and clearly stated in this and other documents promulgated by the professional and nursing education organizations; however, in today’s healthcare delivery system, nursing is faced with unique challenges to fully implementing behaviors that characterize caring within the context of relationships at all levels of practice. Thus, while the climate for nursing coming out of health care delivery changes is one of competing values, the culture of nursing continues to reinforce the importance of caring as core to nursing practice.

While the value of caring within relationships is affirmed throughout educational documents, it is important to recognize that nursing education situated within the system of higher education has changed as well as the role of the faculty in the higher education setting (Finke, 2009). These changes pose threat to nursing’s values. Finke (2009) stated that nursing education is facing a major crisis that seems without end. There is an overwhelming emphasis on increasing numbers of new graduates with fewer resources. Faculty, whose role is to develop curriculum, are faced with meeting this challenge with new and creative curriculums aimed at managing increasing enrollments and within shortened time frames from start to completion of the programs. For instance, there is increased pressure within educational settings as well as from within the nursing profession to develop accelerated and bridge programs that educate in a shortened time frame in spite of demands from the work place for increasing skills and ever

growing knowledge (Jarrin, 2007). In addition, while the curriculum in general is guided by national standards, programs are not mandated to focus on specific curricular concepts within their frameworks; and, there is little evidence supporting the use of one framework over another.

There is evidence that how the new graduate of today has been educated is not preparing him/her for the rapidly changing health care environment. Recent studies, for instance, have identified a disparity between educational preparation and meeting of health care needs in nursing (Berkow & Virkstis, 2008). The Nurse Executive Center, in a study that involved surveying nurse executives and nursing education administrators, identified that only 10% of nurse executives believed that new graduates are prepared to provide safe and effective care; while 90% of nursing education administrators believed that the new graduate is fully ready to provide safe and effective care (2008).

It is important to note, however, that the Nurse Executive Center national study findings indicate that while there is a large disparity between the perception of nurse employers and nurse educators regarding the actual level of preparedness of the new graduate for practice, there is little disparity in regard to what both nurse employers and nurse educators expect as educational outcomes. The existing gap in the preparation for practice of the new graduate, then, appears to be more in the perception of the actual level of preparation of the graduate rather than in the expected outcomes regarding competencies.

Respondents in a 2003 Employer Survey (Smith & Crawford, 2004) identified many important skills for the registered nurse graduate. Therapeutic relationship building skills inherent in a caring relationship are one identified skill set. In regard to nursing education and its outcomes, Watson (2008) has expressed disappointment that the emphasis in nursing education has been “on the head and mind, on rational, cognitive thinking as the basis for teaching-

learning, almost to the exclusion of the heart and emotions” (p. 246) that are essential to understanding and developing caring nurse patient relationships.

Socialization of Nursing’s New Workforce

Nurse workforce and nurse educator statistics have implications for role development of the new graduate. Socialization, the process by which new members learn the values and rules of the profession and become members, is often achieved through a variety of learning experiences that in part are derived from those in clinical practice who serve as role models and, in part by those responsible for the formal education of nurses. The goal is the internalization of a professional identity comprised of factors that include the values, attitudes and behaviors of the profession (Cohen, 1981; Moore, 1969).

The new graduate is entering the complex, changing health care system with role models of several different generations who were guided by differing cultures of healthcare that have influence on new graduate values, beliefs and behaviors. This is at a critical time in health care reform where clear and strong role-modeling is necessary for the new graduate to be able to fully integrate values and practices of caring within their practice. Socialization to the value of caring and healing relationships is a role of experienced nurses.

The nursing program with its curriculum, faculty, and program characteristics has the purpose of preparing a graduate ready to meet delivery demands congruent with the philosophies, values, and skills of the discipline. It has as part of its responsibilities transmitting of the values, beliefs and practices of the profession to those who have chosen to pursue nursing. In addition, it is the role of the faculty to examine the broader changing health care delivery system and its impact on the education of nurses and their role development while incorporating content and methods consistent with both the profession and discipline of nursing and the reality

of the practice environment. Socialization to the value of caring and healing relationships is also a role of the nurse educator and those guiding development of curriculums for nursing.

The disparity between the perceptions of nurse administrators in practice settings and nurse educators regarding the competencies of new graduates includes relationship building, and calls for investigation into the ways of educating graduates to work in today's complex healthcare systems while developing and maintaining caring and healing relationships. Senge, Scharmer, Jaworski, and Flowers (2004) contended that hierarchical leadership is at an end and that distributed, shared networks are the way of the future. Nursing education is positioned between the prospective student population and this changing healthcare delivery system with its need for competent practitioners of nursing at a time of shortage; and, is in a position to participate in shared networks toward achieving mutual goals for nursing and healthcare. The drive to preserve core professional values within nursing's culture, specifically that of caring, is in part what provides significance to this study. In order to investigate the impact of curriculum in the preservation of the value of caring, students educated within a curricular framework focusing on caring were compared with students educated within a curricular framework focusing on systems.

Perspectives on Caring

Caring has been determined to be a universally held value that is the essence of nursing. The members of nursing's workforce have and continue to seek to meet the health care needs of the members of society with a focus on the concept of caring within relationships; a concept viewed by many as the core of nursing practice (Benner & Wrubel, 1989; Leininger, 1988; Watson, 1979). For many, caring approaches have been thought to contribute to the health and well-being of patients' and to facilitate the promotion of health (Baldursdottir & Jonsdottir, 2002; Cronin &

Harrison; Williams, 1998). Parcells and Nelson (2011) proposed that the “dynamic interaction between caring nurses, patients, and families affects discrete changes in measurable units of perceived caring and biochemical markers following caring experiences, resulting in healing” (p. 109) .

Gilligan (1982) spoke of an ethic of care and described a three stage process in coming to an ethic of care The first focuses on caring for self, followed by caring for others and, finally, having the realization of the responsibility for both. Watson (2008) defined nursing from the perspective of caring for self and others. Caring models of practice, such as Relationship-Based Care (RBC), incorporated this perspective by focusing on three essential relationships: with self, with patients, families and significant others, and with colleagues (Koloroutis, 2004).

Study of the concept of caring has been the life time work of Watson (1979; 1985; 1988; 1999; 2003; 2005; 2008; 2009) who developed and continues to expand the Theory of Human Caring. In her works, caring has been presented as a philosophy and a science (Watson, 2008). Nursing is defined as a “human science of persons and human health – illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions” (Watson, 1988, p. 54). The nurse is “an active coparticipant in the human care transactions” (Watson, 1988, p. 54). The relationship with the patient is one of transpersonal human caring. Watson’s original work has continued to evolve and gain depth. In her original work (Watson, 1979) ten Carative Factors were identified as the core of the theory. The intent of these Factors is to differentiate nursing’s care perspective (carative) from medicine’s curing approach (curative). The Carative Factors were identified as the core of professional nursing practice. These factors were further conceptualized as Caritas Processes as the theory transitioned to a caring science (Watson, 2008). Each Caritas Process is drawn from one of the Carative Factors and remains

integral to its Factor. The intent of development of the processes was in part for a more fluid and understandable way to interpreting the depth of meaning of the theory (Watson, 2008).

Within the practice arena some leaders have identified the threat to maintaining the core value of caring and are incorporating models of practice that have caring as the core. One such model, The Relationship-Based Care Model (RBC), aims specifically at the challenges posed by changes in the health care delivery system (Koloroutis, 2004). Supported by transformational change and sustainability, this model is being incorporated in health care facilities across the U.S. It is also being advocated for incorporation into baccalaureate nursing curriculums in the U.S. as one means to address the education-practice disparity by focusing on those values essential to both nursing and the business of health care delivery. The conceptual basis of the RBC model was built on caring theories that include: 1) Watson's Model of Human Care (1999), 2) Swanson's five caring processes (1993), 3) Leininger's theory of Cultural Care Diversity (1993), and 4) Dingman's Caring Model (1999).

Those entering nursing have traditionally been attracted to nursing with the goal of caring and have expressed altruistic purposes for pursuing a career in nursing. Prater and McEwen (2006), in a study of 212 upper division nursing students, found that 46% of them chose nursing to serve others and that 56% identified caring as the primary characteristic important for nurses. The concept of caring is drawn from these altruistic purposes, is the foundation of the nurse patient relationship and is essential within practice models focusing on caring. What is not clearly identified in the literature is the effectiveness of the nursing curriculum of these students in responding to these altruistic purposes as it relates to a focus on caring.

Maintaining a caring presence in the context of relationship aimed at healing is core to the purposes of nursing for the provision of safe, quality care. Caring within the context of

relationships is a value to be protected on behalf of its role in the healing process. In the process of formation of new models for healthcare, transforming exchanges will shape emerging patterns. New patterns may intentionally or inadvertently emerge that challenge the basic premises of any discipline within that organization. The value of providing a culture and climate for development of caring relationships can easily be undermined in today's system. Without attention to the impact of health care delivery changes on the caring dimension of nursing, its value is minimized or lost within the practice setting. Olson and Eoyang (2001) have highlighted that in complex and adaptive systems, interdependence is high and causality is mutual. Therefore, it is critical that nursing identify methods for safeguarding the values and principles of nursing within a complex and business oriented health care delivery system.

Literature on caring in nursing is abundant; however, writings on the effect of caring as a major concept of the nursing curriculum could not be identified. The concept of caring as it relates to education of the nursing student is sparse. Health care institutions using caring focused practice models, however, assume that the new practitioner is well versed in the concept of caring and holds the values inherent within the model as priority in their practice. Yet, no study has been identified that tests this assumption. Questions remain relative to ways in which the student is socialized by educational nursing programs to the value of caring that has been determined as essential to their practice and the models under which they will practice. In addition to a lack of study on socialization of nursing students to caring in nursing, Watson (2003) identified a lack of study comparing perceptions of caring in nursing across different cultures.

This study, while focused on the core concept of caring within the nurse-patient relationship as a reflection of curriculum preparation, is an initial step in the ultimate goal of seeking to

understand factors that may increase sustainability of the value of caring relationships within nursing practice in a healthcare delivery environment that is characterized by a business orientation. Without attention to the impact of health care delivery changes on the caring dimension of nursing, its value is minimized or lost within the practice setting

Problem Statement

Caring models for practice, such as RBC, are being used in health care agencies across the U.S. and in many other parts of the world. Proponents of these models are advocating for incorporation of similar caring models as a framework for curriculum within schools and colleges of nursing. An assumption in the use of caring models is the belief that those who enter the work-force are prepared to practice within the models and that they have integrated the values, knowledge and skills related to caring within relationships. To date, few schools in this country have made the change to a curriculum that focuses on caring as a central framework, while others are in process. In addition, there is little research available to evaluate the impact of caring models in school curriculums or to compare these to other educational models.

Purpose of the Study

The purpose of the study was twofold: 1) to investigate undergraduate nursing student perceptions of caring to determine if those students educated in a nursing curriculum that has caring theory incorporated as a primary focus within the curriculum framework within the U.S. differed from those students educated in a nursing curriculum that has general systems theory incorporated as a primary focus; 2) to investigate if there were differences in perceptions of caring by baccalaureate nursing students from schools with a caring framework in the U.S. and, schools in Thailand.

The study was designed to provide faculty with basic information about the effectiveness of using caring theory as a means for teaching; and, thus, better preparing students to practice within caring models. With the amount of content believed necessary to include in baccalaureate curriculums and the evidence of an education-practice gap that relates in part to the building of relationships, it was and continues to be essential that inquiry be conducted to determine the effectiveness of caring theories on educational outcomes. Since there is no known research about the effects of incorporating caring as it relates to relationship in curriculums preparing students for caring practice models, this study was seen to have the potential for providing a foundation for future inquiry about the incorporation of caring as a core concept of the nursing curriculum. Additionally, the study was designed to provide evidence to support more wide-spread incorporation of content on caring models of practice within baccalaureate curriculums both within the U.S. and in Thailand.

Research Hypotheses

Hypotheses were formulated around research questions that related to: 1) whether there would be a difference in perceptions of the care students provide based on their matriculation in a school curriculum that incorporates a caring model and a school that incorporates a systems model; and, 2) whether there would be a difference in perceptions of student self-care based on the type of curriculum model. Based on the assumptions of the caring model theory, questions related to the relationship of care for others to care for self were posed as well as questions regarding what differences might be identified between U.S. and Thailand students. Level of the student in their program provided baseline data.

Study hypotheses were as follows:

1. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factor Survey-Care Provider Version (CFS-CPV).
 - a. There will be no difference between Southeastern and Thailand Caring Groups' scores on the Caring Factor Survey-Care provider Version (CFS-CPV).
2. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factor Survey-Care for Self (CFS-CS).
 - a. There will be no difference between Southeastern and Thailand Caring Groups' scores on the Caring Factor Survey-Care- Care for Self CFS-CS).
3. CFS-Care Provider and Care for Self total scores for the Southeastern, Midwestern, and Thailand schools will be significantly positively correlated.
4. Entry level students (freshmen and juniors) in the Thailand Caring Group will score higher than Thailand seniors on:
 - a. the Caring Factor Survey-Care Provider Version (CFS-CPV)
 - b. the Caring Factor Survey-Care for Self (CFS-CS)

Significance of the study

The importance of the concept of caring in nursing has been well documented in the literature as is the fact that altruistic characteristics, such as those identified with nursing, attract students to the profession. Caring as an essential concept in nursing has been clearly identified in the statements and policies of the profession and in documents guiding nursing education. However, despite the focus on caring as the essence of nursing, little has been documented on how students learn the attitudes and behaviors of caring. While increasingly practice models with an emphasis on relationship in the context of caring are being implemented in health care

settings, there have been no data to indicate that the new graduate is prepared to practice within a caring model. Inquiry about perceptions of caring by students from programs where emphasis is placed on caring within the curriculum compared to those curriculums where this is not the case, can provide valuable information to educators who participate in the socialization of students into the values, attitudes, and behaviors of the nursing profession. This research may also provide evidence to support the inclusion of models of practice that have a theoretical foundation of caring within the curriculum; models such as Relationship-Based Care.

Conceptual Framework

The conceptual approach for the study was grounded in Watson's (1979, 1988) Theory of Human Caring. This framework was selected because it provides the clearest definition of caring found in the literature; it has been incorporated as the organizing framework for nursing curriculums in a number of schools of nursing; and, valid and reliable instruments have been developed and used extensively in assessing caring across cultures.

The approach is premised on caring as the core of nursing and the understanding that both caring and nursing "reside within a humanitarian as well as a scientific matrix; thus, there is an intersection among the arts, humanities, philosophy, science and technology" (Watson, 2008, p. 19). Core to the concept of human caring is that caring is relational and has an "ethical-moral-philosophical values guided foundation" (p. 29). As a process, it is a conscious and intentional human process that occurs within the therapeutic nurse-patient relationship. Care of self is viewed as integral to the building of caring relationships with others. The theory asserts that when caring is effective, it promotes health and growth of individuals and groups. Caring from Watson's (2003) theoretical perspective is defined by ten Carative Factors and Caritas Processes that are discussed in Chapter 2.

This study, in drawing from Watson's Theory of Human Caring, utilizes the ten *caritas* processes as a basis for student evaluation of their caring practices toward others and self. These processes include: cultivating the practice of loving-kindness; being authentically present; cultivating one's own spiritual practices and transpersonal self; developing and sustaining a helping-trusting relationship; supporting expression of positive and negative feelings; creatively using self; engaging in genuine teaching-learning experiences; creating a healing environment; administering sacred nursing acts of caring; healing by tending to basic human needs, and being open to spiritual/mysterious.

While the conceptual framework is based on Watson's Science of Caring (2008), Leininger's (1981) transcultural approach to caring is important to the study in several ways. First is that she is a "leading proponent of the idea that nursing is synonymous with caring" (McEwen, 2011, p. 223). Second is that she views caring as one of a number of universal concepts in the provision of healthcare. Finally, models of practice often incorporate the transcultural perspective of caring.

Assumptions

Assumptions of the study were related to beliefs grounded in perceptions of both the discipline of nursing and of nursing education. For this study, it was assumed that caring is a central and core concept of the discipline. It was also assumed that caring is universal and can be defined from the perspective of the discipline. In addition, it is believed that caring assumes an approach of wholeness, oneness, and relatedness that encompasses the biophysical, psychological, and spiritual.

Assumptions of the study included a belief that caring can be taught and persons can change through the learning process, gaining breadth and depth of understanding of the concept over

time. Of importance to the study was the belief that the transmittal of a caring approach or attitude within the nursing curriculum occurs through the interpersonal caring interactions of faculty and students. Further, caring behaviors are acquired through transmittal of the culture of the profession and are practiced within the culture and climate of both the didactic and clinical setting. Finally, it was assumed that it is the responsibility of the faculty to develop, implement, and evaluate nursing curriculum that assures preservation of the core concept of caring.

Definition of Terms

Operational definitions help to explain the concepts being explored and guide the researcher and reader in understanding the premises of the study. These definitions provide a common understanding of the terminology and are used consistently throughout the study. This is essential in dealing with concepts that are not clearly delineated in the literature nor operationalized consistently in either practice or education.

Nursing students in this study refer to persons enrolled full or part time in a pre-licensure undergraduate baccalaureate nursing program leading to a bachelor of science in nursing degree (BS in Nursing/BSN) and who are enrolled in courses included in the freshman, junior or senior year of the nursing program. The students included in the study are enrolled in a pre-licensure BSN program in the U.S.A or Thailand.

Systems model nursing program for the purpose of this study is an approved or accredited baccalaureate nursing program admitting students for whom completion of high school or its equivalent is the basis of admission. Systems model refers to those programs that incorporate the concept of systems (VonBertalanffy, 1968) as the major curricular focus determined by curricular document analysis.

Caring model nursing program for the purpose of this study is an approved or accredited baccalaureate nursing program admitting students for whom completion of high school or its equivalent is the basis of admission. Caring model refers to those programs that incorporate the concept of caring (Watson, 1985) within the context of relationships as a major curricular focus determined by curricular document analysis.

Conceptual Framework is the organizing structure for the curricular approach and major concepts of the nursing education curriculum.

Curricular Document Analysis describes a systematic process for reviewing curriculum documents for the purposes of determining whether the concept of caring within the context of relationships is a major curricular focus. Documents included in the review consist of program mission/vision, philosophy, organizing framework, objectives, and course descriptions.

Caring Behaviors are those behaviors identified in Caring Factor Survey – Care Provider Version (CFS-CPV) as indicative of the behaviors necessary for nurses/nursing students in building a therapeutic relationship with patients/clients.

Self-care Behaviors are those behaviors identified in the Self-Care Survey (SCS) as indicative of behaviors necessary for nurses/nursing students in providing care for self as a basis for the ability to develop caring-healing relationships with patients.

Summary

In Chapter 1 the phenomenon of caring within the concept of the nurse-patient relationship as reflected in nursing curriculum frameworks is introduced as the focus of this study. Caring as a core concept of nursing and one that is challenged by the complexity of a changing healthcare delivery system based on a business model is presented. Information is provided regarding the challenges to maintaining nursing's core value of caring. In particular, the need to identify the

effects of curriculum in the learning process of students being socialized into the profession is explained as background to the study purposes. Study purposes were followed by the research hypotheses, and study significance. Watson's (1985) Theory of Human Caring was identified as the theoretical framework for the study. The chapter concluded with general study assumptions followed by a definition of terms for the study.

There are four subsequent chapters. Chapter 2 includes a review of the literature on caring in nursing as well as implications for nursing education and measurements used to assess caring. Chapter 3 presents the research methods for the study including the design, sample, measures, and procedures for the study. Study results are identified in Chapter 4. Finally, in Chapter 5, results are discussed and implications identified for the future.

CHAPTER 2

REVIEW OF THE LITERATURE

The following review was focused primarily on the concept of caring as reflected in the literature and as incorporated in nursing. In addition, a brief look at the literature on Systems Theory (VonBertalanffy, 1968) was included as a basis for differentiating it from Caring Theory (Watson, 1988) which forms the conceptual basis for the study.

While there is considerable literature written on the concept of caring in nursing, there remains a lack of clarity of the concept and varying perspectives on the place of the concept within the organization of nursing knowledge and its role in the metaparadigm of nursing. Identifying a clear definition of caring as a concept within nursing has had its challenges. Finfgel-Connett (2007) highlighted the fact that financial resources traditionally have been devoted to the study of disease and related symptoms, diagnoses, and treatment rather than on more qualitative perspectives of health such as care and caring (Barker, 2000; Euswas, 1993; Gardner, 1992; Leininger, 1993; Turkel, 2001; Woodward, 1997; Yam, 1999).

Researchers have attempted, however, to synthesize various perspectives of caring into coherent structures (Morse, Solberg, Neander, & Bortolf, 1990; 1991). For instance, Morse et al. (1991) identified five views of caring in the literature that include: caring as a human trait; as a moral imperative; as an affect emphasizing emotional involvement, empathy and compassion; as interpersonal interaction; and, as a therapeutic intervention. Morse et al. (1991) note that while five views are identified, it is difficult to find any one view that doesn't include other perspectives.

Within the discipline of nursing, there are nurse theorists and leaders who have perceived care and caring to be a major concept defining its practice and as integral to the essence of

nursing (Crowden, 1994; Eriksson, 1997, Leininger, 1993; Sourial, 1997; Swanson, 1991; Watson 1985). These and other nurse leaders have developed theories of caring at the grand, middle range, and situation specific levels of theory development. Increasingly, health care agencies in addressing the issues related to quality and patient care are implementing models of practice that have caring as central to their models and as the basis for developing the essential human relationships central to the work of nursing. While the concepts of care and caring have been included in nursing curriculums traditionally, there is increased emphasis in some programs today toward increasing content relative to the teaching of caring and models of practice based on caring in a systematic manner and as central to the nursing curriculum. Graduates of nursing programs are entering the practice setting where models of practice are being incorporated that focus on the integration of the instrumental or more technical elements of nursing and the expressive and relational elements based on caring.

One such model of practice was developed by several prominent nurse theorists with an emphasis on those aspects of caring necessary to building and maintaining relationships. The model, titled the Relationship-Based Care model (RBC) (Koloroutis, 2004) is a model of practice derived heavily from the science of caring theory and the works of Watson (1979), Swanson (1991), Leininger (1988), and Dingman (1999). Watson's theory, identified as a grand theory, focuses on the philosophy and science of caring. Swanson (1991) formulated a middle range theory on caring processes, and, Leininger (1994) a theory on culture care diversity and universality. Dingman, while studying the impact of caring practices by nurses with patients and observing the effects on patient satisfaction, developed a model for caring based on techniques for practice.

Duffy (2009) has focused on the serious negative influences of modern health care on the caring value of professionals and on health care outcomes. She goes as far as saying that the professional integrity of nurses may be in jeopardy. She identifies specifically the challenges to caring for new nurse graduates. It is her belief that the gap between professional values and professional practice can be lessened. Duffy's Quality-Caring Model (2003) centers on the linkages between caring and quality and encompasses care for self, patients and families, colleagues, and communities. Research on her model aims at determining the quality of care received as a result of caring behaviors.

There is a paucity of literature relative to students perceptions of caring. And, while there is impetus for building curriculums with caring as central in the conceptual framework of the curriculum, the effectiveness of the inclusion of the concepts of caring within the context of relationships in the nursing curriculum have not been established. There is even less written about the effectiveness of incorporating models of practice based on this approach within the baccalaureate nursing curriculum.

The literature review will serve to summarize findings in the writings on caring in nursing and its incorporation within undergraduate nursing education programs. The perspective of the student of nursing, as presented in the literature, will also be discussed. In addition, the Relationship-Based Care model will be described as an example of one approach to strengthening the incorporation of caring skills in the practice setting as well as strengthening content relative to the concept in baccalaureate nursing programs.

Caring in Nursing

Many in nursing have spent their professional careers inquiring about the essence of nursing and the place of caring as a core concept of the paradigm that guides the discipline of

nursing. While not universally held by all nurses, there is a body of literature regarding the concept as it applies to nursing; and, is therefore worthy of reflection.

In examining the literature on care and caring in nursing, two qualitative meta-syntheses were identified with the focus of caring in nursing. The first was conducted by Sherwood (1997). The second, published ten years later by Finfgeld-Connett (2007), was an enhancement of the findings of Sherwood and was an attempt to enhance understanding of the concept of caring by using an inductive approach. Over 534 qualitative studies and concept analysis were identified. Based on meeting the purposes of the analysis, findings from 49 qualitative reports and six concept analysis were included in her synthesis. As a result of the meta-analysis, caring was described as “an interpersonal process that is characterized by expert nursing, interpersonal sensitivity and intimate relationships” (p. 198). In addition antecedents were identified that include a need for caring, an openness to it by the recipient, as well as professional maturity and a moral foundation by the provider; and, an environment conducive to embracing caring. She described that the consequences of the caring relationship are shared by both the patient, who experiences a positive change in physical and mental well-being; and, the nurse who expresses a higher level of mental well-being.

Finfgeld-Connett (2007) concluded that the findings in the meta-synthesis are consistent with quantitative studies using factor analysis (Wu, Larrabee, & Putnam, 2006). She also found congruence with a meta-synthesis she, herself, completed on nursing presence. Her recommendations included that more resources be allocated for development of caring in both practicing nurses and students; and that, additional research be conducted toward clarifying various elements of the process of caring.

Caring is a major concept of nursing theories such as Watson's theory of human caring (1979) and Leininger's theory of culture care (1988). Watson (1979) identified ten carative factors for nursing that include: humanistic-altruistic system of values; faith-hope; sensitivity to self and others; helping-trusting human care relationship; expressing positive and negative feelings; creative problem-solving caring process; transpersonal teaching-learning; supportive, protective, and/or corrective mental, physical, societal, and spiritual environment; human needs assistance; and existential-phenomenological-spiritual forces. These factors are the outcome of Watson's (2008) desire to address "those aspects of professional nursing that transcended medical diagnosis, disease, setting, limited and changing knowledge, and the technological emphasis on very specialized phenomena" (p. 30) and to address the core of nursing. It is believed that the science of caring defines nursing and is complementary to medicine's science of curing.

More than twenty years after developing the carative factors, she identified *caritas* processes for the practice of nursing. These are described as a more expressive language for the original factors. The caring factors and *caritas* processes are the foundation in preparing practitioners for the practice of the philosophy and science of caring in nursing. Each of the *caritas* processes is drawn from one of the caring factors (Watson, 2008). These processes are identified in Table 1.

The Theory of Human Caring, more currently ascribed to as the Science of Caring, consists of assumptions and descriptions of dimensions of care. For instance, it is assumed that an environment of caring within which caring responses are provided facilitates acceptance of persons not only as they are at any given moment but for what they may become. Additional assumptions are that persons have the choice in selecting the best action for their selves (2008).

Of importance is the emphasis of the theory on oneness, wholeness, unity, relatedness, and connectedness. In this model, there are multiples ways of knowing that includes acceptance of various forms of evidence. Watson (2005) provided additional assumptions as follows:

Table 1.

Watson's Caring Factors and Caritas Processes

Caring Factor	Caritas Process
Humanistic-Altruistic System of Values	Cultivating the Practice of Loving-Kindness and Equanimity Toward Self and Other as Foundational to Caritas Consciousness
Installation of Faith and Hope	Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other
Cultivation of Sensitivity to Oneself and Others to Caritas Process	Cultivation of One's Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self
Developing a Helping-Trusting Relationship to Caritas Process.	Developing and Sustaining a Helping-Trusting Caring Relationship
Promotion and Acceptance of the Expression of Positive and Negative Feelings to Caritas Process	Being Present to, and Supportive of, the Expression of Positive and Negative Feelings
Systematic Use of the Scientific Problem-Solving Method for Decision Making to	Creative Use of Self and All Ways of Knowing as Part of the Caring Process: Engage in the

Caritas Process	Artistry of Caritas Nursing
Promotion of Interpersonal Teaching and Learning	Engage in Genuine Teaching-Learning Experience that Attends to Unity of Being and Subjective Meaning --- Attempting to Stay Within the Other's Frame of Reference
Attending to a Supportive, Protective, and/or Corrective Mental, Physical, Societal, and Spiritual Environment	Creating a Healing Environment at All Levels
Assistance with Gratification of Human Needs Administering Sacred Nursing Acts	Administering Sacred Nursing Acts of Caring- Healing by Tending to Basic Human Needs
Allowing for Existential-Phenomenological Forces	Opening and Attending to Spiritual/Mysterious and Existential Unknowns of Life-Death

- An ontological assumption of oneness, wholeness, unity, relatedness and connectedness.
- An epistemological assumption that there are multiple ways of knowing.
- Diversity of knowing assumes all, and various forms of evidence can be included.
- A Caring Science Model makes these diverse perspectives explicitly and directly.
- Moral metaphysical integration with science evokes spirit; this orientation is not only possible but also necessary for our science, humanity, society-civilization, and world-planet.

- Caring Science emergence, founded on new assumptions makes explicit an expanding unitary, energetic, worldview with a relational human caring ethic and ontology as its starting point (p. 28).

Leininger's work on transcultural nursing provided additional perspective to the concept of caring. She states that "caring is the central and unifying domain for the body of knowledge and practices in nursing" (Leininger, 1981, p. 3). Leininger (1988) identified that caring is a human need that is essential and within every culture. In the study of caring in numerous cultures, she has identified caring as essential in growth and survival as well as in facing death. She further stated that the expression of care varies across cultures and that cultural care values, expressions, and practices need to be known for nursing to be therapeutic. Nursing is identified as a transcultural care profession and discipline (Leininger, 1994). Through her work, universal characteristics of health have been identified, including that of caring.

According to Swanson (1991), who developed a middle range theory of caring derived from the work of Watson (1999), caring is defined as "a nurturing way of relating to a valued, other toward whom one feels a personal sense of commitment and responsibility" (Swanson, p. 165). Important in the study on caring in nursing is the "capacity for caring to enhance healing and the potential to find meaning in human experiences of health and illness" (Swanson, p. 165). While developing a middle range theory of caring, Swanson investigated the concept of caring through a comprehensive literature review using an inductive process of inquiry that was validated through phenomenological investigations. Three studies were conducted within the context of the peri-natal environment. The outcome of her study was a definition of caring and identification of characteristics of caring that are represented through five caring processes: knowing, being with, doing for, enabling, and maintaining beliefs (1991). She identified sub-dimensions that serve to

further clarify the meaning of each of the caring processes. Table 2 lists these subdivisions (Swanson, 1991, p. 163).

The work of Watson (1985) related to carative processes and that of Benner (1984) on the helping role of nursing were used to cross validate the caring processes (Swanson, 1991).

Table 2

Sub-dimensions of the Five Caring Processes

Knowing	avoiding assumptions; centering on the one cared for; assessing thoroughly; seeking cues; engaging the self of both
Being With	being there; conveying ability; sharing feelings; not-burdening
Doing For	comforting; anticipating; performing competently/skillfully; protecting; preserving dignity
Enabling	informing/explaining; supporting/allowing; focusing; generating alternatives/thinking it through; validating/giving feedback
Maintaining Belief	believing in/holding in esteem; maintaining a hope-filled attitude; offering realistic optimism; 'going the distance'

Dingman's (1999), The Caring Model, described specific activities nurses carry out in their interactions with patients that include: introducing self to the patient; addressing the patient in a specific manner; appropriately using touch; spending a specific time with the patient while sitting and planning/reviewing care and outcomes; and reinforcing organizational , vision and values.

Brilowski and Wendler (2005) have characterized caring as having two components, instrumental and expressive. Those aspects of care that are physical and technical are conceptualized as instrumental; while those that relate to psycho-social and emotional needs are conceptualized as expressive. Larson (1981) clarified that tasks and treatments, cognitive-oriented activities such as problem solving, and teaching are instrumental.

McCance, Slater, and McCormack (2008) studied caring from a humanistic perspective and in relationship to person-centeredness. They, too, identified the illusiveness of the concepts in the literature but emphasized the importance of both caring and person-centeredness within nursing. Their approach is based on the principles of a human science approach using those presented by McCance, McKenna, and Boore (1999). Principles of person-centeredness include those incorporated by McCormack, McCance, Slater, McArdle, and Dewing (2008)) and include respect, rights of individuals, values and beliefs, understanding and therapeutic relationships. McCormack (2001) implied that the understanding of the patient as person and how that impacts on the understanding and expectations within a relationship is important to the nurse-patient relationship. Consistent with Finfgeld-Connett's (2007) findings, McCance, et al. (2008) identified that there are prerequisites to relationship that focus on the nurse and these include competence, having interpersonal skills, commitment to the job, an ability to be clear about beliefs and values, and knowing oneself. Considering the environment in which care are provided is also considered essential in achieving effective patient care outcomes.

Duffy (2003) developed the Quality-Caring Model in response to the need to acknowledge the linkages between the values of nursing and evidence-based practice. She emphasized relationships that are characterized by caring as influencing positive health care outcomes. Her

work aimed at identifying the linkages between human caring and quality care from a conceptual, theoretical and empirical perspective.

In 2003, Watson published an article that identified the lack of study in directly comparing perceptions of caring across cultures in nursing. In response, a survey method was used to identify differences and similarities in the perception of caring between nurses in Spain and the UK. The Caring Dimensions Inventory (CDI-25) was used to identify differences in the perception of caring by the nurses in these two countries. The study identified broad similarity in individual components of caring between the two groups as identified in the CDI-25; however, it was also found that the Spanish and UK nurses ascribed different levels of importance to the individual items. Reasons for these differences were not the focus of the study, but a recommendation for future study.

Patients' Perceptions of Caring.

The literature revealed that patient perceptions of caring varied somewhat from those of nurses. Patistea and Siamanta (1999), in writing for the Greek community, conducted a review of the literature on caring. Their purpose was to heighten sensitivity to caring behaviors so that clinicians might be aware of the perspectives of the patient. The results of the literature review, of both quantitative and qualitative study reports of caring, found that nurse clinicians focus on the psychosocial aspect of caring; whereas, patients focused foremost on technical skills and professional competence. A small proportion focused on clinical expertise as primary. Physical and emotional absence, belittling and inhumane actions, and lack of recognition of the uniqueness of the patient were viewed as non-caring behaviors. The reviewed literature included studies focusing on patient perceptions over a 35 year period from 1962 through 1997.

While the results of the literature findings were aimed directly at patient perceptions, a brief statement was made about nurse educators. It was identified that nurse educators' perceptions viewed instrumental (technical) skills as most important in a caring situation.

Subsequent to the 1997 literature review, Baldursdottir and Jonsdottir (2003) conducted a study to determine patient perceptions of nursing caring behaviors in the emergency department. Watson's theory of caring (2003) formed the theoretical basis for the study. Human needs assistance was identified by patients as the highest rank subscale in the study, placing emphasis on knowing what action to take, how to do tasks, and when to contact the physician (p. 67).

In a 2008 study by McCance, Slater, and McCormack, the Nursing Dimension Inventory (NDI) (Watson, Deary, & Lea, 1999) was used to identify patients' perceptions of caring and the Caring Dimensions Inventory (CDI) was used to identify nurses' perceptions of caring with differing groups of patients and nurses at five times over a two year time period and within the context of a person centered practice. In this study, nurses perceptions of caring were consistent over time; however, patient perceptions were not consistent across all indicators. Involving the patient in care was a consistent indicator for patients. The authors conclude that the inconsistency in patient perceptions relates to different expectations of patients and affirms the need for nurses to come to know their patients and to use the perspective of the patient in promoting a person-centered approach to achieve patient goals.

Nursing Students Perceptions of Caring

Though there is a paucity of literature relative to the perceptions of caring by nursing students, articles that are written provide insight into the dimensions of caring that have been studied in a variety of countries. The studies conducted aimed at identifying the students' perception of caring, changes in this perspective as the student progressed in their baccalaureate

nursing program, the importance of caring from the perspective of the student, and similarities/differences in various cultures. Many of the studies recommend further investigation into the teaching of the concept within the curriculum.

Wilkes and Wallis (1998) developed a model of caring from the perspective of the student. Compassion was identified as the core of caring and was expressed in their communication, comfort measures, professional competence and behaviors, and in their own courage. Watson, Deary, and Lea (1999) conducted a longitudinal study using the Caring Dimensions Inventory (CDI) to detect changes in caring by students across three years of their nursing curriculum. The CDI used in the study is a 35 item questionnaire in which students identify statements as indicative of caring or not. Exploratory factor analysis was used in which four factors of caring were identified. A fifth factor was identified in the second year of testing that related to accountability. The findings of the study were that student nurses were able to perceive both professional and technical dimensions of caring. In addition, the student's caring perceptions increased over time. On admission, caring and nursing were not viewed as synonymous; however, toward the end of the program the two concepts were more synonymous. Scores, however, also revealed a loss of idealism. Reasons for this loss could not be determined and further research was recommended. The authors recommended that further investigation focus on determining whether perceptions of caring and nursing change as a result of the nurse education program of the student and whether changes are attributable to classroom or clinical components of the program.

In 2001, Watson, Deary, and Hoogbruin conducted a longitudinal study in Scotland with a sample of 168 students at the onset of the study. At time two there were 124 students and at time three, 90 students. The purpose of the study was to ascertain the perceptions of caring among

nursing students and how these develop over the course of their nursing program. At the onset, nursing students perceive the technical dimensions of nursing. Psychosocial and other aspects were perceived more clearly as they progressed in the program. The instrument used for the study was the Caring Dimensions Inventory (CDI); however, a second purpose of the study was to develop a 35-item version of the instrument by adding items that might expand some of the dimension of the previous CDI-25. In the thirty five item instrument, five factors were identified compared to four factors in the lesser item instrument. In the longer item instrument, the psychosocial aspects of nursing reflected two factors, one identified as intimacy and the other as supporting aspects of nursing.

In 2004, Granum conducted a study with students from Norway in which first and third year students' concept of caring was studied. First years students viewed care as it was known in their daily life, while third year students understanding of the concept reflected the knowledge for the practice of professional nursing that incorporates a caring science.

Karaoz (2004) studied Turkish nursing students' caring perceptions. The perspective of this author is that caring is fundamental to nursing and that caring outcomes are a result of teaching/learning processes while students are in their education programs. In this study, caring themes were in two groups including the "professional/helping relationship and technical competency" (p. 34). This qualitative study with a sample of 19 senior level nursing students surfaced characteristics of respect, compassion, concern and communication as basic to the helping/professional relationship. Technical competency was described as knowledge and skills of nursing. Specific examples were provided for each of the two categories. The author compares the student views as being affirmed by those of Leininger (1998) and Watson (2003).

Khademian and Vizeshtar (2007), using the Caring Assessment Questionnaire (Care-Q) instrument, collected data from Iranian nursing students to determine the importance of caring behaviors. It was assumed that caring is essential in nursing and that nurse educators have an important role in the education of caring nurses. In this study a variety of behaviors were identified as more or less caring. Interestingly, activities involving carrying out of technical type skills received highest importance among these students and trusting relationships the least importance. Gender was not statistically significant. In addition, there was no significant difference in student perception of caring at the various levels of the program, sophomore through senior. The authors recommend evaluation of curriculum innovations aimed at improving learning of caring concepts as well as cultural competence.

Finfgeld-Connett (2007) referred to professional maturity and a moral foundation by the provider in her meta-synthesis of the literature on caring. Karaoz (2005) found that nursing students put emphasis on the ethics in nursing and the emotional support within the nurse-patient/client relationship. She supports this finding as consistent with similar findings in other studies (Beerman, 1997; Berlandi, 1997; Fowler, 1989; Maier-Lorentz, 2000; Mooney, 1988; Swanson, 1993).

More recently Murphy, Jones, Edwards, James, and Mayer (2009) examined whether nursing students' perceptions of caring behaviors within the context of nursing practice changed over the course of their undergraduate nursing program. The Caring Behaviours Inventory (CBI) (Wolf, Colahan, Costello, Warwick, Ambrose, & Giardino, 1994) was used with two groups of students from the United Kingdom. Eighty to ninety baccalaureate nursing students each in the first and third year of the nursing sequence completed a questionnaire using the CBI. A statistically significant difference in the means in caring behaviors was found between first and

third year students with third year students scoring lower than first year students. The difference increased for those less than 26 years of age and more greatly if they had no caring experience. The conclusion of the authors was that the education process itself reduced caring behaviors. Komorita, Doebling, and Hirschert (1991) assumed that the teaching of caring is a component of the nursing curriculum and that students in later years of the program have a more realistic understanding of the concept of caring; thus, accounting for such changes.

Caring Based Practice Models: Relationship-Based Care

Practice models provide a structure for the delivery of care that supports the values and beliefs of nursing. Practice models based on caring are increasingly being implemented in practice settings. Relationship-Based Care (RBC) is one such model of care purported to provide a context by which to address important challenges of nursing and healthcare. As is evident from the title, the model is about relationships and caring. Knowledge and skills related to relationships have been identified by nursing administrators of health care agencies as a gap in education for the newly practicing graduate. Thus, a model of care that focuses on relationships has the potential for bridging this area of the education/practice gap. Three crucial relationships are incorporated in the RBC model. These include the care provider's relationship with patients and families; with self; and, with colleagues. Its philosophical basis is grounded in the belief that the essence of care is in that moment when human beings connect (Koloroutis, 2004). Koloroutis (2004) affirms that the patient and their family and significant others is the focus and that what is most important is unwavering respect and concern for the identified needs of patients, safeguarding of their dignity, and engaging them in their care.

In accord with the RBC Practice Model and Watson's definition of nursing (2008), it has been emphasized that nurturing one's own self knowing and care is essential to understanding

and meeting patient needs and in contributing effectively to the health care organization goals. Finally the RBC model acknowledges that strong relationships among all members of the health care team are essential in the provision of safe care. Each member, from whatever discipline or area of work, must be able to respect and affirm the work of the other and be able to function interdependently.

Koloroutis (2004) stated that “the Relationship-Based Care model promotes organizational health resulting in positive outcomes in all the critical arenas that measure success: clinical safety and quality, patient and family satisfaction, physician and staff satisfaction, effective recruitment and retention of staff, and a healthy financial bottom line” (p. 6). While relationships of caring are integral to the model, they are only one of its characteristics. The model provides a philosophical foundation and structure for the provision of care. It is amenable to incorporation across health care settings and is interdisciplinary.

Several nurse theories/models provided the framework for the practice model including Watson’s (1988) model of human care; Swanson’s (1991;1993) middle range theory of caring and the five caring processes; Leininger’s (1994) culture care diversity; and Dingman’s (1999) application model on caring. Manthey’s (2002) delivery model of primary nursing is incorporated in the professional role dimension of the RBC model. The RBC model is grounded in the principles of transformational change, in particular, that developed by Felgen (2007).

Felgen’s (2007) model aims at transformational change in culture and is represented by the I₂E₂ insignia: inspiration and infrastructure, education and evidence. In her model, inspiration is described as leaders having a clear vision and purpose, the confidence and ability to influence others, and a focus on what is the essence of nursing – “caring and healing relationships at the point of care” (Koloroutis, 2004, p. 7). An infrastructure that is strategic and operational is

essential in supporting the vision of an institution. Felgen (2004) identified the importance of education in the development of self-awareness, understanding of the patient, and family experience, developing and maintaining healthy relationships, fostering critical thinking and leadership, and utilization of creative approaches. She further emphasized person's potential and the power of a culture of appreciation in promoting one's potential. Underlying the ability to engage in change are the concepts of clarity of vision, perceived competency, confidence in making change, and willingness to collaborate and be committed to change. The change model is an iterative process involving on-going evaluation of outcomes, reflection, decision-making, and change.

There are seven dimensions to the RBC model with each encompassing concepts of a caring and healing environment. A caring and healing environment is about the physical environment; but, equally important is that it is about respect for the dignity of each person and emphasis on relationships between health care team members and those served. A shared commitment to healing is essential. An environment characterized by caring supports all other dimensions of the model.

Implications for Nursing Education

Increasingly it is being emphasized that nursing education and practice must collaborate more closely to align education with practice (Kimball & O'Neill, 2002). Furthermore, both health care institutions and educational institutions are being encouraged to increase resources devoted to development of caring within their respective facilities (Coyle-Rogers & Cramer, 2005; Lee-Hsieh & Turton, 2004; Touhy, Strews, & Brown, 2005). Models of practice, that include an emphasis on the building and maintaining of relationships within a context of caring and that utilize theoretical models of caring, are increasingly being implemented within

healthcare facilities. The Institute of Medicine (IOM, 2003) in reporting on the challenges to health care clearly identified that health profession education needs to change to meet the needs of today's society. This report also identified core competencies for those who are educating health professionals.

The American Association of Colleges of Nursing (AACN, 2008), a nursing organization who has as one of its responsibilities the accreditation of baccalaureate and higher degree education programs, has included the core competencies from the IOM (2003) report in its education essentials (Finkelman & Kenner, 2009). AACN has an established framework for baccalaureate education that includes, content, behaviors, and outcomes expected of baccalaureate nursing graduates. This framework is used in the process of accrediting schools and colleges of nursing. In presenting the essentials of baccalaureate education, professionalism and professional values is presented from the perspective of professionalism as demonstration of core values. These values relate to nurses in collaboration with others working to achieve optimal health and wellness by 'wisely applying principles of altruism, excellence, caring, ethics, respect, communication, and accountability' (Interprofessionalism Measurement Group, 2008, p. 26).

Nursing students, then, are the recipients of the concepts included in the curriculum and the role-modeling of faculty who are responsible for the development and implementation of the curriculum. Caring, as a component of the curriculum aimed at development of the professional nurse, is an essential concept in student socialization.

General Systems Theory

Systems theory has been long used as a means to conceptualizing the connectedness of a broad number of concepts that are seemingly unconnected. The theory was appropriate for

nursing at a time when the concepts of the discipline were being defined and shaped in relation to one another. It was used as a means for understanding the relatedness of concepts that were emerging to give definition to the discipline: person, environment, health, and nursing (Doheny, Cook, & Stopper, 1987). This derived theory was used by King (1971) and others as the conceptual framework for formulating grand theories for nursing.

Systems concepts were derived from General Systems Theory as formulated by vonBertalanffy (1968). General Systems Theory was developed in the early 1900's to counter logical positivism and the heavy emphasis on the parts of systems. In the theory, the system is a basic unit or entity. It has both subsystems (components contained within it) and supra-systems (components outside of it) that interact and influence the whole. The resultant effect of the interaction of the various levels of systems is that, working in concert; the whole is greater than and different from the sum of the parts. Individual parts do not contain the properties that are derived from the unique blend of parts interfacing one with the other; that is, the whole is greater than and different from the sum of the parts.

Systems have structure that is identifiable. Processes also occur throughout various systems that are dynamic with a change in any one part of the system or its components affecting the other parts. The interchange of the various components of the systems is toward maintaining a dynamic balance, homeostasis, or steady state. Feedback is a regulation process across the systems and serves to use outputs from the systems to maintain its steady state and to maintain the organization of the system. Organization is identified as negentropy, while disorganization is referred to as entropy. Change occurs in the process of maintaining system organization.

General Systems Theory concepts have been used in nursing as a basis for theory building and development of the discipline. It is a broad and all-encompassing approach to visualizing a

wide variety of concepts in any given situation while giving credence to that which occurs that is different from the total of all parts (Sieloff-Evans, 1991). The theory has also been used as an organizing framework for nursing education curriculums as it facilitates a holistic conceptualization of the numerous aspects of nursing important in the education of students.

Measurements of Caring

Watson (2009) acknowledged and discussed the variety of views regarding the meaning of caring in nursing and its place within the discipline. She also identified that opposing perspectives on the concept and its place in nursing has resulted in tension about methodologies for measurement. She has made the point that through continued study, in spite of duality of perspectives, the nursing community may gain knowledge to assist in understanding of the concept of caring and its role in the discipline. She has given indication that a goal is the identification of caring-based models to affect cost and outcomes that may improve the workplace for both the professional and the patient. While there is controversy regarding the best method for measurement of caring, both quantitative and qualitative methods have been used. As with other concepts, perhaps both types of methods are important in establishing credibility for the science of nursing.

Beck (1999) in a literature review of measures of caring in nursing identified that eleven quantitative caring instruments had been used of which eight measured the concept through the use of a Likert scale, two with analogue scales one using a checklist and one a Q-sort. Beck (1999) investigated these quantitative instruments, providing a variety of information on each of them that includes the definition forming the basis for use of the instrument, a description of the instrument, and the intended population to be assessed as well as reliability and validity and the

use of the instrument in identified research studies. The theoretical basis on which each instrument was developed is also described.

A variety of instruments using Likert Scales include: Caring Behaviors Assessment (CBA), Caring Behaviours Inventory (CBI), Caring Dimensions Inventory (CDI), Holistic Caring Inventory (HCI), Caring Ability Inventory (CAB), and the Client Perception of Caring Scale (CPCS). The Caring Behaviours Assessment Tool (Cronin & Harrison, 1988) was developed based on the carative factors described by Watson (1985) and is intended for use with patients. The instrument has 63 nurse indicators across seven subscales. The instrument was initially used in the United States. In 2002, it was used in a study with patients in the emergency room setting in Iceland to determine nursing behaviors believed by patients to be indicators of caring and to determine the most to least important characteristics of caring (Baldursdottir & Jonsdottir, 2002). Patients ranked clinical competence as the most important characteristic of caring, supporting Watson's factor of actions taken on behalf of the patient in the process of practice.

The revised Caring Behaviours Inventory (Wolf et al., 1994) is used for both patients and nurses. It has revealed the dimensions of nurse caring to include respectful deference to others; assurance of human presence; positive connectedness; professional knowledge and skill; and attentiveness to the other's experience" (Beck, p. 28).

In 1997 Watson and Lea developed the Caring Dimensions Inventory (CDI-25) to measure nurses' perceptions of caring. It is a self-assessment of perceptions of caring. The intent of the instrument was to identify themes of caring as well as information on the sources of nurses' caring knowledge. The 41 item questionnaire was administered initially to nurses and subsequently in a longitudinal study to nursing students in Scotland (Watson, Deary, & Lea, 1999). The instrument was also used in studies to identify differences in the perception of caring

between older and younger nurses (Watson & Lea, 1998) and between nurses in two types of nursing units (Watson & Lea, 1999). A study published by Watson et al. in 2003 also used the instrument to compare differences and similarities in caring of nurses in Spain and the UK. In 2001, Watson, Deary, and Hoogbruin developed a 35-item version of the caring dimensions inventory (CDI) to investigate the structure of caring with attention to appropriate and inappropriate self-giving; two smaller factors from the original CDI.

The Holistic Caring Inventory (HCI) was developed by Latham (1988) for use with patients to determine nurse caring based on the holistic dimension of humanistic caring theory. The Caring Ability Inventory (CAI) by Nkongho (1990) is based on elements of caring believed to be critical in defining the concept (knowing, trust, hope, and others) and was used in a study to determine whether practicing nurses would have a higher score on caring elements than college students. Statistical significance was achieved. The Caring Attributes Scale (Nyberg, 1990) was developed for use with nurses and to determine caring behaviors.

The Caring Behaviors Checklist (CBC) and the Client Perception of Caring Scale (CPCS) (McDaniel, 1980) were developed to be used concurrently. The CBC is aimed at identifying observed behaviors of nurses related to caring and the CPCS at measuring the client's response to nurse caring behaviors using a 10-item Likert Scale.

The CARE-Q (Larson, 1981) was developed to investigate nurse caring behaviors from the perspective of patients and nurses. The instrument has been used with special populations such as coronary care patients and nurses (Rosenthal, 1992). The instrument was used in one study with nursing students (Mangold, 1991). Reliability of these studies is not reported. In 1993 Larson and Ferketich developed a new questionnaire that incorporated 50 items from the CARE-Q into a visual analog scale with an additional twenty-one items to measure satisfaction with

nurse caring behaviors and renamed it the Care Satisfaction Questionnaire (CARE/SAT). In 1988, Hinds developed the Caring Behaviours of Nurses Scale (CBNS), a 22 item visual analog scale to measure patients' perception of nurse caring.

More recently several instruments have been developed that have been used specifically with nursing students. The first is a revision of the Caring Professional Scale authored by Swanson (2000). This instrument was derived from her caring theory and originally used with the maternity population in a National Institute of Medicine Nursing Research funded study. The instrument was used to evaluate the nurse and the care given at the time of miscarriage of women. In its revised form, it has been used with students; however, reliability and validity has not yet been reported (Nelson, 2011).

The Caring Assessment Tool (CAT) developed by Duffy (2007) has several versions aimed at patients, administrators, and educators. The conceptual basis of measurement is Watson's theory of human caring. The patient version aims at obtaining patient perceptions of caring behaviors of nurses. The version for administrators (CAT-admin) was designed for use with staff nurses to gain their perceptions of the caring behaviors of nurse managers. The education version (CAT-edu) of the instrument is intended to measure the perception of students of caring factors exhibited by faculty. The CAT-edu is the newest version of the instrument and is still under refinement.

Coates (1997) developed the Caring Efficacy Scale (CES) to measure confidence in a person's ability to express caring and to establish a caring relationship with patients. The conceptual basis of the scale includes both Bandura's self-efficacy theory (1977) and Watson's theory of human caring (Watson, 2009, p. 163).

The Caring Factor Survey (CFS) (Drenkard, Nelson, Rigotti, & Watson, 2009) is a relatively new instrument to examine the concept of *caritas*, as developed by Watson (2008), based on contemporary views of caring in the context of health care. *Caritas* is a human attribute representing the connection between caring and universal love (Drenkard et al., 2009). Watson's theory outlines ten carative factors. These factors are elements existing within the patient and nurse provider. The CFS recognizes not only the connections between caring and universal love, but also between self-caring practices. The instrument was developed for a federally funded research project (Nelson, Watson, and InovaHealth 2008, 2009). Validity and Reliability have been established for the instrument (Watson, 2009). A provider version (CFS-CPV) was subsequently developed for use with care providers, including nursing students. It is comprised of 20 statements using a Likert scale regarding provider perceptions regarding the care that is given to patients.

Since the inception of the CFS and the CPV, several additional adaptations or versions of the instrument have been developed and tested for use in measuring relationships with self and relationships with co-workers. These are the Caring for Self (CFS-CS) version of the CFS and Caring for Co-Workers (CFS-CC). In determining instruments for this study, available instruments, the purpose of each instrument, the conceptual definition of caring, the population to which the specific instrument is applicable, the length of time for administration, and the reliability and validity of the instruments were assessed.

CHAPTER 3

RESEARCH METHODOLOGY AND PROCEDURES

Introduction

The health care delivery setting and its institutions are organized as complex and changing business-oriented systems focused on quality outcomes, lean performance, and fiscally sound practices. The values of this complex, business oriented system often conflict with the values of the profession of nursing that have aimed at building caring relationships for meeting the health care needs of patients. Interdisciplinary models of practice, such as those focused on a theoretical basis of caring, are being implemented within healthcare agencies and aim to address the difference in values between the business and professional nursing orientations. The Relationship-Based Care Model (RBC) of practice is an example. This model has as its theoretical basis, the science of caring as formulated by Watson (1979; 1985; 2009) who has been on the forefront as a leader in the study of caring as a science. The core of nursing from Watson's perspective is the caring relationship established between nurse and patient. In addition, forming of caring relationships is predicated on the nurses' care for self and colleagues. Caring is viewed as a universal concept.

Nursing students complete programs of study aimed at educating and socializing the student to the profession and discipline of nursing within the healthcare delivery system. Nurse leaders have identified a gap between the education of nurses and what is expected in the practice setting. One of the areas of discrepancy relates to building relationships within the practice setting. Whether the student enters a practice environment with a strong practice model based on caring in all of its dimensions, such as RBC, or one of several other models that include relationship building with patients, families, other professionals and support staff, a caring

approach is expected in relationship building. There is little evidence, however, about which types of nursing curriculums best prepare students for their role in caring as it relates to relationships.

In this chapter the research methodology used for examining the effect of curriculum on student perception of caring are described including the study design, purposes, settings and sample, instrument measures, independent and dependent variables, data collection procedures, and data analysis. In addition, ethical components of the study are addressed.

Study Design, Purposes and Hypotheses

This descriptive, comparative study was designed to explore curriculum effects reflected in nursing students' perceptions of caring for self and others using Watson's (1985) Caritas Processes. Quantitative methods were used to collect and analyze data related to the research purposes. The purpose of the study was twofold:

- 1) to investigate undergraduate nursing student perceptions of caring to determine if those students educated in a nursing curriculum that has caring theory incorporated as a primary focus within the curriculum framework within the U.S, differ from those students educated in a nursing curriculum in the U.S. that has general systems theory incorporated as a primary focus;
- 2) to investigate if there are differences in perceptions of caring by baccalaureate nursing students from schools with a caring framework in the U.S. and, schools in Thailand.

In accord with the purposes of the study, the specific aim was to explore the relationship between perceptions of caring of senior level, baccalaureate nursing students and the emphasis of the baccalaureate nursing curriculum of the school in which they were enrolled (Caring Model or Systems Model). Perceptions of caring included those related to care of self and those related to

care of others. To provide baseline data for the study and to strengthen study methods, it was determined that data would also be collected on entry level nursing student's perceptions of caring.

Research hypotheses for this study included:

1. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factory Survey-Care Provider Version (CFS-CPV).
 - a. There will be no difference between Southeastern and Thailand Care Groups' scores on the Caring Factor Survey-Care Provider Version (CFS-CPV).
2. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factory Survey-Care for Self (CFS-CS).
 - a. There will be no difference between Southeastern and Thailand Care Groups' scores on the Caring Factor Survey-Care for Self (CFS-CS).
3. CFS-Care Provider and Care for Self total scores for the Southeastern, Midwestern, and Thailand schools will be significantly positively correlated.
4. Entry level students (freshmen and juniors) in the Thailand Caring Group will score higher than Thailand seniors on the Caring Factory Survey-Care Provider Version (CFS-CPV).
 - a. the Caring Factor Survey-Care Provider Version (CFS-CPV)
 - b. the Caring Factor Survey-Care for Self (CFS-CS)

Settings and Sample

A variety of nursing schools were considered as the setting for the study. In order to study curriculum effects as a result of a curriculum framework utilizing caring, schools with a theoretical framework based on caring were selected for comparison to an alternative curriculum

framework. For this study a framework incorporating systems as the major concept in the curriculum was selected based on the wide use of the systems model in nursing education over the past forty years. Specific baccalaureate nursing programs representative of these two types of curricular models, caring and system, were identified for comparison using a process of consultation with experts and document analysis for caring components in the curriculum.

Since socialization to the profession occurs initially in the undergraduate nursing program and within the school setting, it was determined that students who were close to completing their course of study (senior level) in programs representative of the two curricular models would serve as subjects for the research. Entry level students were determined to be appropriate in providing baseline data for comparison with data from senior students. Selection of the settings for the study and the students who participated were carefully determined to obtain likelihood of a high degree of representation of the two different curriculum models.

Settings

Three universities having baccalaureate nursing programs with relatively similar class sizes were selected for the study. The academic settings selected included schools or colleges of nursing having a curriculum conceptual framework that was grounded strongly in the concept of caring or a curriculum conceptual framework that was built on a curriculum emphasizing concepts of systems theory. A school of nursing in a university in the Southeastern U.S and a school within a University in Thailand were selected for having a curriculum based on caring and specifically using Watson's Caring model. A Midwestern nursing school in the U.S. was selected based on a General Systems model (vonBertalanffy, 1968) curriculum,

The nursing programs, in the U.S. and Thailand, were initially selected with the assistance of persons who have expertise in curriculum development and knowledge about the type of

curriculum model being implemented in various schools. Subsequent to identification of possible schools for the study, a document analysis procedure was used to confirm the presence of a caring model or a systems model of curriculum. These procedures are described in the procedures section of this chapter.

The Midwestern University is a major public research and teaching institution with nursing as one of its schools. The School of Nursing offers a baccalaureate program for traditional and RN students. Students in the traditional program are admitted to the nursing courses in the junior year of the program. In addition to the baccalaureate program, the school offers a Master of Science Degree program as well as Doctor of Nursing Practice and Doctor of Philosophy Degree programs. The program built its philosophy and conceptual framework using a systems approach.

The Southeastern University is a large public institution that houses the College of Nursing. The College offers a baccalaureate degree for traditional, accelerated and registered nurse students. In addition, it has Master's, PhD, and DNP programs as well as accelerated tracks from undergraduate to graduate degrees. The program philosophy is caring-based and the conceptual framework derived from caring theory, specifically that of Watson. Similar to the Midwestern School of Nursing, students enrolled in the traditional program are admitted to nursing courses in the junior year of the program.

The nursing College in Thailand is a private, religious based College, offering a baccalaureate degree for traditional nursing students. It also offers a Master's Degree in Nursing Administration. There are plans for addition of a doctoral nursing program in the future. Students are admitted directly to the nursing program in the freshmen year. Each of the three nursing

programs selected for the study admit approximately 100 students to their nursing program each year.

The Dean of each nursing program was contacted by e-mail. The study was described and its purposes explained (See Appendix J – E-mail Correspondence with Deans of Participating Schools). Permission was requested to conduct the study and a request was made for a contact person who could provide information on the best procedures for data collection, serve as the primary informant for questionnaire distribution and return to the researcher, and provide support regarding any other questions or concerns that may arise relative to the study or study procedures. Affirmative responses for participation were received from each school.

Sample

Student groups were selected from each nursing program based on curriculum type (Caring vs. Systems model) in order to compare students' perception of self with perceptions of provider care. A convenience sample of senior level undergraduate nursing students from each of the three programs constituted comparison groups. In determining power, Cohen's (1988; 1992) factors for assessing sample size were considered including the significance level, effect size that can be tolerated, and the estimated variance. Group size was selected using the G*Power 2 program with an alpha of .05, power of .85, and effect size of .25. This program performs high-precision statistical power analysis for statistical tests in research. It has proven effective in determining study power for research that uses t-tests, F-tests, and Chi²-tests (Erdfelder & Buchner, 1996).

The projected samples for this study included the Southeastern Caring Group consisting of 75 senior student volunteers from the Southeastern University. A second Caring Group, referred to as Thailand Caring Group, was projected to consist of 75 senior student volunteers from a

University in Thailand. The Midwestern Systems Group was projected to include 75 senior students from the Midwestern University. In addition, the sample was projected to include equivalent groups of entry level students from the U.S. schools having a caring model curriculum or a systems model curriculum, as well as, 75 entry level students from the Thai school with a caring model curriculum. These groups were identified as Caring Group from the Southeastern University, Caring Group from the Thailand University, and Systems Group from the Midwestern University. The data collected from the student groups from each school were to be used for baseline comparison of perceptions of caring.

Both U.S. nursing schools (the Southeastern University and the Midwestern University) admit students in the junior year of the nursing program. The Thailand University admits students in the freshmen year of the program. To maintain consistency throughout all three study groups (U.S. Caring, U.S Systems, and Thailand Caring) the year of entry to nursing (junior or freshmen) were to be used for comparison with senior level nursing students. Data collection procedures were followed in detail as described in the procedures section.

Subject inclusion criteria included nursing students from the selected baccalaureate nursing programs who were enrolled as senior level nursing students and who graduated within the academic year of the study (2011-2012). At the time of questionnaire completion, nursing students were pre-licensure students enrolled full or part time as traditional, accelerated, second degree or LPN to BSN students. All students completing the questionnaires met these criteria. No students were excluded on the basis of gender, age, marital status, race or ethnicity, religious affiliation, socio-economic status, grade point average or reasons for selecting nursing. Entry level nursing students included in the study were those pre-licensure nursing students admitted to

their respective program and who had not yet enrolled in senior level nursing courses. All other inclusion criteria were met for these students.

Theoretical Concepts and Operational Variables

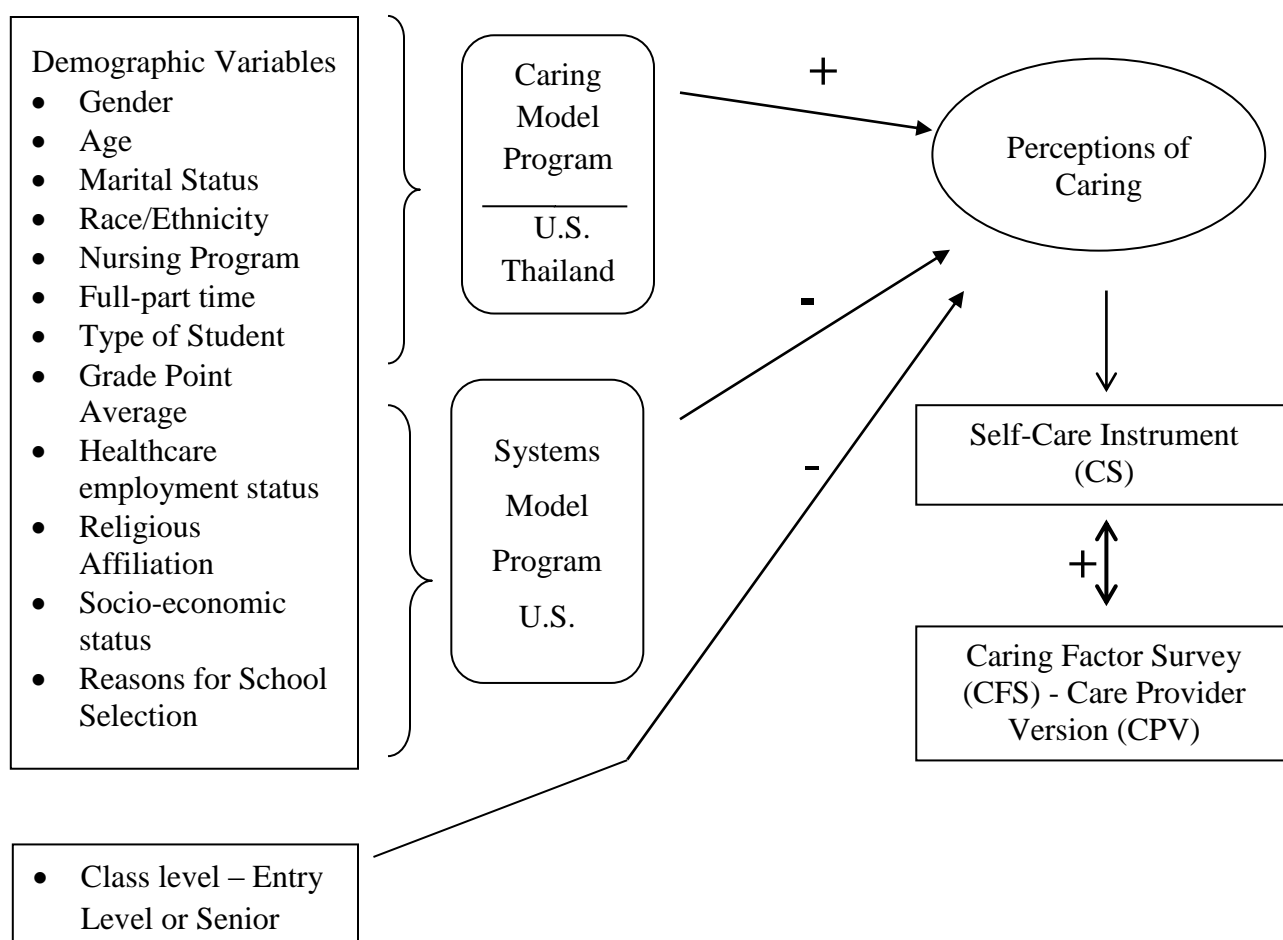
The study variables included the independent variables: nursing programs in the U.S. that have incorporated a Caring Model focus within the BSN curriculum; nursing programs in Thailand that have incorporated a Caring Model within the BSN curriculum, and, nursing programs in the U.S. that have incorporated a Systems Model focus within the BSN curriculum. Senior level students from each of these programs were tested to determine the relationship with the dependent variables, nursing students' perceptions of caring for self and nursing students' perception of care for others (i.e. patients/families). It was hypothesized that students in both the U.S. Southeastern Caring Group and Thailand Caring Group would have higher scores on the CFS-CPV and the CFS-CS compared to students in U.S. Midwestern Systems. In addition, it was hypothesized that there would be no difference in perceptions of caring by U.S. Southeastern Caring Group and Thailand Caring Group on the CFS-CPV and the CFS-CS.

The relationship of the variables (demographic, independent, and dependent) and outcome measurements are depicted in Figure 1. The plus (+) and minus (-) signs indicate the hypothesized direction of the relationship between the independent and dependent variables.

It was anticipated that the perception of students from nursing programs with a curriculum organized around a caring model would score higher on the CFS-CPV than those students from nursing programs with a curriculum organized around a systems model (Hypothesis 1). Additionally, it was anticipated that the perception of these same students from a caring model curriculum would score higher on the CFS-CS than those students from a systems model curriculum (Hypothesis 2). It was also anticipated that the perceptions of caring of entry level

students from the Thailand School would score higher than senior level students on both measures (Hypothesis 4). Senior level students have experience that provides a more actual picture of the concept and what is required to establish caring relationships. Finally, the diagram indicates a positive relationship (Hypothesis 3) between self-care as indicated by scores on the CFS-CS and care as a provider based on Watson's premise that in order to establish caring relationships with others, the nurse must first provide care to oneself.

Figure 1: Theoretical Model and Outcome Measures for Examining Perceptions of Caring in Baccalaureate Nursing Programs with and without caring integrated as a central concept in the curriculum framework.



Measures

Participants were asked to complete three questionnaires. The first was to provide demographic information. The second was to ascertain perceptions of care provided to others, and the third to ascertain perceptions of self-care.

Demographic Questionnaire

Students were requested to complete a demographic questionnaire that was available in English (Appendix E) and Thai (Appendix F). Back translation procedures were followed for the Thai version of the demographic questionnaire. Responses to questions on demographics were analyzed to determine the effect of these factors on the findings and are presented in Chapter 4. Demographic variables included: 1) gender of participants; 2) age; 3) marital status; 4) race and ethnicity; 5) nursing program; 6) full or part time status; 7) type of student (traditional, LPN to BSN, accelerated, other); 8) overall grade point average as reported by the participant; 9) healthcare employment status; 10) religious affiliation; 11) socio-economic status of participant; 12) reason for choosing nursing school; and, 13) class level – entry level (freshmen, sophomores, or juniors) or seniors.

Due to the fact that the carative factors and caritas processes that define the caring process in nursing include spirituality, information was gathered on religious affiliation. It is understood that concepts of spirituality and religious affiliation are defined differently; however, persons often do not make these distinctions personally. Clarification was also being sought relative to whether a school with a strong component of caring in the curriculum may attract a specific type of student; thus, the reason for inquiring about reasons for selecting the school of attendance. Only two students from the school with a caring curriculum model stated that they selected the school based on the ‘caring philosophy’. Besides assisting in determining the effect of the

demographic factors on findings related to caring in the curriculum, analysis was conducted to provide insight about other possible areas of research on this topic.

Caring Questionnaires

Two instruments were used for measurement, including the Caring Factor Survey-Care Provider Version (CFS-CPV; Appendix A – English; and, Appendix B - Thai) and the Caring Factor Survey-Care of Self (CFS-CS; Appendix C – English; and, Appendix D – Thai). The CFS-CPV and the CFS-CS instruments were derived from the Caring Factor Survey (CFS) developed by Drenkard, Nelson, Rigotti, and Watson as a part of a nationally funded research project in collaboration with InovaHealth (Nelson, Watson & InovaHealth, 2006). In its original form, the instrument was developed to measure patients' perception of caring behaviors of the health care provider. Watson's Theory of Caring and the carative factors provide the theoretical basis of the instruments.

The Caring Factor Survey (CFS), from which the CFS-CPV was developed, had been tested and had been determined to be valid (Nelson, DiNapoli, & Turkel, 2011). In regard to construct validity, both translation validity and criterion-related validity were established. Face validity was established by the authors, Watson and Nelson (Nelson, 2005). Two questions were formulated for each caritas process for a total of 20 statements. Content validity was established by Watson and other experts in caring science and the caritas processes.

Criterion validity was assessed by measuring the instrument against the Caring Assessment Tool (CAT-II) (Duffy, Hoskins, & Seifert, 2007). The CAT-II also is based on Watson's theoretical perspectives. Internal consistency of the CAT-II was calculated at .9776 in several studies (Andrews, Daniels, & Hall, 1996; Duffy, 2002). Pearson's correlation was then used to determine the relationship between the two instruments when used with the same patients and

units. The correlation was .69 at a .10 significance level. Predictive validity was also established (Watson, 2009).

The original version of the CFS was determined to be internally consistent and, therefore, reliable. Correlations of paired statements were conducted to determine that the statements were measuring caring behavior. All correlations were found to be significant at a .001 level. A Cronbach alpha of .97 and .98 were determined in three separate studies (Watson, 2009).

The original form of the CFS was written and used in English. Subsequently it has been translated into Filipino, Italian, Portuguese, and Spanish. There are currently seven different versions of the instrument that has extensive testing described by DiNapoli, Nelson, Turkel, and Watson (2010) and Nelson, Watson, and Inova Health (2009). The first instrument used for this study was the CFS-CPV questionnaire.

Caring Factor Survey – Care Provider Version (CFS-CPV).

The Caring Factor Survey-Care Provider Version (CFS-CPV) was derived from the Caring Factor Survey (CFS). Johnson (2011), in collaboration with Watson and Nelson adapted the CFS, creating the CFS-CPV, for use with health care providers, including students, to measure their perceptions of caring for patients. The major adaptations to the original version were to change the caritas statements from the patient perspective of the care received to ‘I’ statements from health care providers about care given.

The CFS-CPV is a 20-item semantic differential 7-point Likert scale with responses ranging from 1 (strongly disagree), 4 (neutral), and 7 (strongly agree). The instrument measures provider perception of the care that is being provided for the patients under their care; thus, providing information about caring derived from the clinical setting. All questions are positively stated (Watson, 2009). Higher scores indicate greater perception of caring. The full English version of

the questionnaire with student directions for seniors can be found in Appendix A and in Thai in Appendix B.

The CFS from which the provider version was derived has been widely tested and has established validity and reliability. During development of the adapted version of the instrument (CFS-CPV), power analysis using G*Power 2 revealed a need for 50-60 participants. Seventy-six providers that included 55 RNs, 14 LPNs, 2 APNs, and 5 others completed the CFS-CPV. Use of a t-test revealed no differences in RNs and LPNs using a .05 alpha. A .92 Cronbach's alpha was found. Descriptive statistics were calculated for the caritas processes with mean scores ranging from a high of 6.55 to a low of 6.21 (7-point Likert scale of 1-7). Questions derived from the caritas processes scored highest to lowest in the following sequence: allow miracles; loving kindness; teaching and learning; promoting expression; faith and hope; holistic care; supporting spiritual belief; helping and trusting; problem solving; and healing environment (Johnson, 2011).

Careful consideration was given to use of the research instruments for students from a culture different from the U.S.; that of Thailand. Steps were taken to minimize error in translation that might lead to results occurring to factors other than real similarities or differences (Maneesriwongul & Dixon, 2004). Back translation was used as has been recommended by experts in cross-cultural research (Brislin, 1973; Champman & Carter, 1970; Werner & Campbell, 1970). For the current study, the CFS-CPV was administered in English to students surveyed in the U.S. Back translation procedures were used in translating the CFS-CPV into Thai for students taking the survey in Thailand. The instrument was translated into Thai by a native of Thailand and back translated by both a nursing faculty from Thailand who is currently a U.S. citizen and a graduate student from Thailand. The translated instruments were also independently reviewed by a second graduate student who is a native of Thailand. These persons were fluent in

English as well as Thai in order that comparisons could be made between source and target language versions. Minor differences were found in the translation related to the word spirituality in the first review. Adjustment was made in the translation. The Thai translated instrument used in this study will provide data for future analysis in establishing the reliability and validity of the instrument. The translated instruments performed well for this study.

A copy of the translated, full questionnaire with directions for seniors is found in Appendix B. Directions for entry level student completion of the CFS-CPV were adapted to reflect responses related to care that the students believe they would provide to patients. These are included in Appendix G (English) and Appendix H (Thai). Though the instrument is in the public domain, permission was received for its use from the authors who forwarded an electronic copy of the English version of the instrument.

Caring Factor Survey – Care of Self (CFS-CS).

The theoretical perspective of caring science is that “the most vital relationship outside of the care provider and patient relationship is relationship to self, which includes perceived competence of caring and caring behaviors toward self” (Nelson & Watson, 2011, p. 35). It is believed that the relationship and its healing connections between patient and nurse cannot be attained fully if nurses do not care for self. In order to ascertain perception of caring reflected in care of self. The Care of Self (CS) instrument was selected for measurement.

The Care of Self (CS) version of the CFS was developed by Lawrence (Nelson, personal correspondence, 2011) with the permission of Nelson, one of the authors of the CFS. In this questionnaire each of the two questions for the ten carative factors in the original CFS are combined into a single question for each factor and questions are formulated from the perspective of care of self. The CFS-CS is a 10 item semantic differential 7-point Likert scale

with responses ranging from 1 (strongly disagree), 4 (neutral), and 7 (strongly agree). One open-ended question was included to ascertain the respondents' perception of the attitude, behaviors, and/or actions upon which their responses were based. Lawrence and Kear (2011) tested the instrument in a study of nurses and patients in a critical care unit. Reliability was established with Cronbach's alpha scores of 0.89. The average mean score for the instrument in this study was 5.66. Study results indicated that nurses in this setting did not provide for care of self.

This instrument was administered in English to those students in the U.S. The CFS-CS was administered in Thai to students at the Thai school. The same back translation procedures were followed in the development of the CFS-CS as were used in development of the CFS-CPV. Persons conducting the back translation were consistent for all questionnaires used in the study.

The open ended question relating to perceptions of the reasons for responses was analyzed for themes. Responses were typed for each participant responding to the question. They were listed by setting (Southeastern School, Midwestern School, and Thailand School). Major themes were identified for each setting, and frequency of type calculated. Themes and frequency by setting and in aggregate were determined.

Procedures

Selection of the Settings

Settings were carefully selected to represent a wide diversity between caring model programs and models focusing on systems concepts in the curriculum. For this study the systems model was selected as the model to be compared to the caring model. The process for selection focused on identifying experts from each type of curriculum model; and, within the U.S. and in Thailand. Procedures included document analysis and initial contact for permission for inclusion of the schools in the study.

Recommendation of experts.

Experts having knowledge and experience with the two curriculum models were consulted. For the model having a theoretical foundation based on theories of caring, persons with expertise in incorporating caring practice models in health care institutions and persons familiar with caring sciences and caring curriculum models were contacted. In addition, the familiarity of faculty with curriculum development and teaching was considered in identifying experts. It was also considered important that the faculty expert had knowledge of the educational system and curriculum in the U.S. and in Thailand.

Personnel from Creative Health Care Management, the group that is spearheading the implementation of the Relationship-Based Care Practice Model (RBC) based on Watson's caring theory, were contacted for recommendations of schools/colleges that incorporate the RBC model within the curriculum. Subsequently, Watson, the author of the grand theory on caring science and a nurse educator herself, was contacted for recommendation of names of schools in the U.S. implementing caring as core to their curriculum.

Faculty curriculum experts with longevity working in the U.S. nursing educational system and having expertise in the development and implementation of a systems curriculum model provided recommendation for the school with a systems model. These persons also had familiarity with the proposed study.

A faculty, originally native to Thailand, and having knowledge and continuing contacts with schools in Thailand provided assistance in identifying a school from that country whose curriculum is built on caring. A school meeting the criteria for the study was identified. Attempts to identify a school in Thailand whose curriculum was based on a systems model and that could be feasibly included in the study were unsuccessful; therefore, it was determined that comparison

would be made only with U.S. schools and Thailand schools having a caring curriculum model and U.S. schools having a systems model.

Schools and colleges were limited to those having baccalaureate programs. Efforts were made to select schools of similar size and having similar programming within the U.S. and the Thailand education systems.

Curricular document analysis.

Following the identification of possible schools for the study, curriculum documents from each identified school (caring and systems models) were reviewed and a document analysis conducted by the researcher to identify the presence of caring as the major concept threaded throughout the curriculum documents of each program. The process for document analysis of the curriculum for this study is derived from that used by Waterman (2007) in analyzing a baccalaureate curriculum that used caring theory and carative factors (Watson, 2003) as a strong component within the curriculum. The purpose of Waterman's work was to "describe a curriculum that teaches caring in the formal, overt curriculum, that is, where caring has been explicitly operationalized in the content and learning experiences of students" (Waterman, 2007, p. 4).

The process used for Waterman's study included exploration of faculty and student perceptions of caring and analysis of curriculum documents using Watson's carative factors. The use of Waterman's process based on Watson's caring factors provides congruence with the document review process for this study since the caring factors are also used in the measurement instrument for the current study. The document analysis portion of her process involved a review and re-review of the nursing program's mission statement, college goals, philosophy, and program objects for the core concept of caring.

Document review using a systematic process was thought to be important in validating that the schools identified as having caring as a core component of the curriculum were clearly differentiated from those having core components other than caring; in this study systems. It was also determined to be important in providing validation about the formal and overt aspects of the curriculum of each school as it relates to caring and as decided by the faculty, expressed in their written documents, and integrated within the content of the courses. The college vision/mission, goals, philosophy, program objective, and catalog and course descriptions were analyzed for evidence of the concept of caring, Watson's Theory of Caring, and other concepts of caring. The analysis is presented in narrative and table format in Appendix I. An effort was made to obtain heterogeneous populations in order to be able to identify variability.

Permission from participating schools.

Upon completion of identification of nursing programs that seemed likely to meet study purposes and completion of document analysis to provide confirmation to the initial analysis, an e-mail letter was forwarded to the Dean of each of the schools describing the study and requesting permission for participation. The name of a contact person who could assist with the study was also requested. Each of the Deans responded affirmatively to the request and provided a contact person; or, in the case of the Thailand School, the Dean agreed to be the contact person (Appendix J). These persons handled all aspects of data collection and return to the researcher.

Institutional and Human Subjects Approval

The Human Subjects Committee procedures were followed for the University of Kansas. An exempt review was requested based on the level of risk. See Appendix O for the 'Human Subjects Approval for Exempt Status' letter. The study was approved and copies of the approval letter were forwarded to personnel at each school participating in the study. Contact persons

within each of these institutions completed the individual review processes and notified the researcher that approval was received for proceeding with the study. The research has been monitored carefully in relation to collection and maintenance of data as well as analyzing and reporting the findings.

Data Collection

Data collection procedures were established with regard for ethical practices in conducting research. Ethical conduct, minimal risk to the nursing programs and students, informed and voluntary agreement by participants, confidentiality of information, and avoidance of deception and/or concealment were carefully considered in establishing data collection procedures. Human Subjects approval request forms were completed and submitted with subsequent approval to conduct the study. The letter of approval following review is contained in Appendix O.

Data collection assistants.

The designated contact person from each school was contacted to assist with research study procedures. The best method for obtaining access to students, method for contact, and procedures were discussed.

In order that students may be knowledgeable about the study and what their participation in the study would entail, the researcher communicated with the contact person relative to the purposes and significance of the study. The identified persons were asked to distribute materials to participants or to provide these to another faculty member who then assisted with the procedure. The materials were provided to nursing students at each level prior to, during, or following a specific class as agreed upon prior to mailing of questionnaires.

The contact person was advised that students were to be asked to complete two short survey type questionnaires consisting of a total of 30 questions to be answered using a Likert Scale. In

addition, they were advised that there was a demographic questionnaire to be completed. It was discussed that completion of the three questionnaires was anticipated to take 20 minutes or less.

Measures distribution and collection.

Arrangements were made with an outside agency, Health Care Management, for the purposes of obtaining a template for the questionnaires to be used in the U.S. schools. Upon receipt of the template, questionnaires were printed and a packet of questionnaires was collated for each student in the U.S. schools participating in the study.

Following discussion and agreement as to the particular procedures to be used in each school for obtaining student participants a follow-up letter with collated students packets that included a student information letter in English (Appendix K) or in Thai (Appendix L), the CFS-CPV questionnaire in English (Appendix A) or Thai (Appendix B), the CFS-CS questionnaire in English (Appendix C) or in Thai (Appendix D) and, a copy of the demographic questionnaire in English (Appendix E) or in Thai (Appendix F), as well as guidelines for distribution were sent to the contact person. See Appendix M for the follow-up letter and Appendix N for the distribution guideline sheet. Researcher contact information, including e-mail addresses and telephone numbers of the student and her advisors were included in the materials sent to the designated contact persons. The researcher provided extra pencils for students, a return box, mailing tape, and postage for questionnaire returns.

For the Thai School, back translation procedures were followed and the researcher prepared a template of the questionnaires that were e-mailed to the Thailand school where the questionnaires were copied and collated in student packets for administration. Reimbursement was provided for questionnaires that were air expressed back to the researcher.

Students received information about the study in an announcement made before, during, or following a designated class as agreed upon by the contact person. The contact person or her designee was asked to describe the study purposes and significance. He or she was also asked to announce that participation was voluntary. That participation is voluntary was also included in the student letter accompanying the questionnaire and demographic sheet.

The research took place within the school setting and using paper/pencil questionnaire format. The designated person for each school was asked to be responsible for collecting all questionnaires and returning them to the researcher who then forwarded them to a professional group hired to oversee entering of data into SPSS #20 (SPSS, 2012) data base for analysis. Questionnaires of students agreeing to participate as well as those of students who elect not to participate were asked to be returned in order to obtain knowledge on rate of return. The designated contact persons were asked to return extra packets separate from those that were distributed to students. Each questionnaire was given a code that was not in any way connected with a student identifier. The code was removed as soon as the data were entered into the data base.

The designated contact persons returned questionnaires by mail in a pre-addressed, stamped USPS box following administration of the questionnaires. An envelope was provided, for any remaining questionnaires beyond the number actually distributed. This envelope was included in the box with the distributed and returned questionnaires. Questionnaire return took longer than anticipated and required periodic e-mails and/or telephone calls related to the progress of the study.

Participant information and instruction.

Each beginning and senior student present at the time of the research study announcement received a packet containing a letter that described the study purposes and procedures, information regarding risk and benefits to the student, and, that completion of the questionnaires represents permission to participate in the study. The student letter also contained information that questionnaires would take approximately 20 minutes to complete. The letter also contained information on student participation, confidentiality of data, and use of data.

As previously indicated, the CFS-CPV and the CFS-CS questionnaires as well as the demographic questionnaire written in the applicable language, English or Thai, were included in the packet. Directions for completion of the questionnaires were provided on the questionnaire forms. Questionnaires were completed in pencil or black or blue ink.

The name, address, and e-mail of the researcher were provided should there be student questions or concerns. The student was requested to return the questionnaires to a box at a place identified by the designated person who then returned them to the researcher. Finally, the student was advised that a request could be made for a summary of the results and findings at the completion of the research if wished. An e-mail address was provided for requesting the information.

For the seniors in each program, data were collected within the last three months prior to graduation. Data were collected on entry level students as follows: junior nursing students at the Midwestern school; sophomore and juniors students at the Southeastern school; and first and third year nursing students at the Thailand school. Whether data were collected on entry level students in the freshmen, sophomore, or junior year related to availability of access to students. It was not possible to collect data until the end of the second semester of the respective year of enrollment at each school setting.

Students not wishing to participate were asked to return the uncompleted questionnaires to the return box that was provided. Students who were willing to participate completed the questionnaires and also returned them to the box that was provided. Students were advised not to record their names on the questionnaires. Questionnaires have been retained in a locked file at the office of the researcher.

Follow-up Procedures

The contact persons from the Southeastern and Midwestern nursing programs returned the questionnaires in a self-addressed, stamped U.S. Post Office box to the researcher who reviewed them for completeness and forward them to Healthcare Management for assistance with data entry. The contact person from Thailand air expressed the questionnaires and was reimbursed the costs. These questionnaires were reviewed, a translation guide provided and the materials forwarded for data entry.

No monetary or other awards were given to students. The benefit to the student was in contributing to knowledge related to understanding the role of nursing programs in teaching caring. A thank you e-mail was sent to program personnel assisting with recruitment and testing procedures. No student requests for study results have been received to date.

The nature of the questions included in the survey poses no obvious threat or risk of harm to an individual student, though a particular student may have been uncomfortable if s/he thought that answering at a lower level on the Likert Scale inferred that s/he was uncaring or that his/her school would be viewed negatively. The benefit to the student was in actual participation in a research study and becoming familiar with selected aspects of the study.

There was no direct risk to the schools/colleges involved; however, there may have been concern regarding whether curricular outcomes were being met related to the inclusion or non-

inclusion of the concept of caring. Advantages to the school include the value of having data for program evaluation and information for external accrediting agencies. The data and study results received may provide information for further curriculum review considerations.

Data Analysis

Research methods for the study were selected to support a descriptive and comparative study, and are, therefore, non-experimental. The purpose of the study was twofold:

- 1) to investigate undergraduate nursing student perceptions of caring to determine if those students educated in a nursing curriculum that has caring theory incorporated as a primary focus within the curriculum framework within the U.S, differ from those students educated in a nursing curriculum in the U.S. that has general systems theory incorporated as a primary focus;
- 2) to investigate if there are differences in perceptions of caring by baccalaureate nursing students from schools with a caring framework in the U.S. and, schools in Thailand.

The major limitation of this type of study was that cause cannot be exclusively determined. In addition, there were limitations imposed by the challenge to obtaining data from entry level students. The approach, however, has revealed information about program types that will provide the basis for further study. In addition, further questions have been raised regarding perceptions of students about caring. Strength of this study was in the use of a theoretical model, Watson's Caring Theory, as the basis of study, as a factor in participant selection, and in the measurement instrument.

Data Entry and Management

Questionnaires received from each participant were scanned and retained for future referral. The paper copy was also maintained in a separate file. Data from each of the two

caring questionnaires and demographic questionnaire were entered into SPSS #20 (2012) for windows in preparation for analysis. Seniors from all three programs were used for analysis of Hypotheses 1 and 2 and their respective sub-hypotheses. Seniors from all three programs and entry level students from Thailand were used in the analysis for Hypothesis 3 and 4.

Students from the Thai Caring School who had not yet enrolled in a senior level nursing course were determined to be 'entry level students'. The data from these students was used in the analysis of Hypothesis 4. The nursing program in Thailand admits students to nursing in the freshmen year of the program, unlike the two U.S. nursing programs who admit in the junior year of the program. Since little was known about similarities and differences in these students, an attempt was made to collect data from both freshmen and juniors in each program. Sufficient returns were received from both freshmen and juniors in the Thailand school; therefore, only the Thai sample was used in comparisons for entry level students.

Entry level freshmen and junior nursing students from Thailand having a caring model curriculum were compared with seniors in Thailand having a caring model curriculum. This data provided a basis for gaining insight about the perceptions of Thailand students prior to program socialization completed in the senior year and provided information for further study.

Descriptive indexes of each variable, including the demographic variables, were identified and reviewed. Data were entered into the statistical computer program SPSS #20.0 for Windows (SPSS, 2012) and were reviewed to assess for cleanness and quality of data. The data were also reviewed for outliers and missing data. It was determined that additional procedures were not needed to address missing data. The data were also reviewed for variability and describing of the sample.

Descriptive indexes of each of the three independent and dependent variables were also determined and frequency charts prepared following examination of the data for cleanness and quality of data. Missing data were identified and decisions for handling of cases were made. Descriptive statistics for the independent and dependent variables included total and subscale results.

Reliability of Measures

Two instruments were used for the study, the Caring Factor Survey – Care Provider Version (CFS-CPV) and the Caring Factor Survey – Care for Self (CFS-CS). As discussed more fully in the section on measurements of caring in Chapter 2 and the measures section of the current chapter, the two instruments used for this study were derived from the Caring Factor Survey that has been used repeatedly with established reliability and validity.

Subsequent to development of the CFS-CPV two studies were completed that established reliability and validity of the English version of the instrument. The first study was conducted in a 651 bed hospital system where a caring model of practice (Relationship-Based Care) was being implemented (Hozak & Brennan, 2011). The survey was available in English and Spanish. A total of 382 employees on two campuses of the hospital that included nurses and non-nurses completed this questionnaire. There were no statistical differences when comparing campuses using a .05 alpha. Mean scores for all items representing the carative factors were above 6.0.

The second study was also conducted in an acute care facility using a quasi-experimental nonrandomized between subjects design (Herbst, 2011). This study also served to confirm the reliability and validity of the CPV.

The CFS-CS was developed by Lawrence, who requested that the CFS be amended for self-care (Nelson, Personal Communication, 2011). Content validity for these versions was

established by the authors of the CFS and Watson. Reliability was established through testing (Lawrence & Kear, 2011).

Sample Demographic Data

Frequencies were calculated for nominal variables (marital status, race, ethnicity, program type, class level, full or part time study, type of student, healthcare employment, religious affiliation, socio-economic status, and reason for choosing their nursing school). The ratio variable of socio-economic status was converted to a nominal variable. Frequency distribution tables that include both count and percentage were prepared. The mean was calculated for age and grade point average. Standard deviations and ranges were also derived for age and grade point average as a measure of variability. Cross tabs were computed and Pearson Chi-Square applied. Significant variability was found among the demographic variables posing questions for further study. As a result of variability identified in the demographics, post-hoc testing was done where appropriate to confirm initial findings.

Hypotheses Data Analyses

Hypothesis 1.

1. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factory Survey-Care Provider Version (CFS-CPV).
 - a. There will be no difference between Southeastern and Thailand Caring Groups' scores on the Caring Factor Survey-Care provider Version (CFS-CPV).

Relationships were identified between the independent and dependent variables. These findings were reflected on contingency tables. Cross tabulations were used for ease of visualization. Inferential statistical testing was used to compare differences in perceptions of

caring among groups of senior students using data from the Caring Factor Survey-Care Provider Version (CFS-CPV). An ANOVA test was applied to test for any statistical significance of difference between the means of the study groups in the main hypothesis using data from the Caring Factor Survey -Care Provider Version (CFS-CPV): U.S. Southeastern Caring group and Thailand Caring group with U.S. Midwestern Systems Group. An ANOVA was also applied for the sub-hypothesis to determine statistical significance using the CFS-CPV when comparing the U.S. Southeastern Caring group with the Thailand Caring Group. A .05 significance level was used. An ANOVA was applied rather than separate t-tests in order to lessen the probability of a Type I error and falsely rejecting the null hypothesis.

Hypothesis 2.

2. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factory Survey-Care for Self (CFS-CS).
 - a. There will be no difference between Southeastern and Thailand Caring Groups' scores on the Caring Factor Survey-Care-for Self CFS-CS).

Relationships were also identified between the independent and dependent variable. The findings were reflected on contingency tables. Cross tabulations were again used. Inferential statistical testing was used to compare differences in perceptions of caring among groups of senior students using data from the Caring Factor Survey-Care for Self (CFS-CS). An ANOVA test was applied to test for any statistical significance of difference between the means of the study groups in the main hypothesis using data from the Caring Factor Survey -Care Provider Version (CFS-CS): U.S. Southeastern Caring group and Thailand Caring group with U.S. Midwestern Systems Group. The ANOVA was also applied for the sub-hypothesis to determine statistical significance using the CFS-CS when comparing the U.S. Southeastern Caring group

with the Thailand Caring Group. A .05 significance level was used. As was the case with hypothesis 1, an ANOVA was applied rather than separate t-tests in order to lessen the probability of a Type I error and falsely rejecting the null hypothesis. When appropriate, Levene's statistics and box plots were used to assess for homogeneity of variance.

Hypothesis 3.

3. CFS-Care Provider and Care for Self total scores for the Southeastern, Midwestern, and Thailand schools will be significantly positively correlated.

This hypothesis was to analyze the relationship between the two measures (CFS-CPV & CFS-CS) for participants from all three schools, anticipating that senior students, who scored high on care of others, would also score high on care of self. Pearson's correlation coefficients were applied to determine the correlation.

Hypothesis 4.

4. Entry level students (freshmen and juniors) in the Thailand Caring Group will score higher than Thailand seniors on the Caring Factory Survey-Care Provider Version (CFS-CPV).
 - a. the Caring Factor Survey-Care Provider Version (CFS-CPV)
 - b. the Caring Factor Survey-Care for Self (CFS-CS)

Independent T-tests were used to assess differences in caring scores between senior level students from Thailand and entry level (freshmen and juniors) students from Thailand. Pearson's r was applied to assess whether senior level BSN students who score high on the CFS-CPV from each of the three Groups will also score high on the CFS-CS.

Analysis of variance (ANOVA) was applied to determine mean group differences as reflected in the F ratio for entry level nursing students in Thai freshmen and Junior Caring Groups with seniors in the Thai Caring Group.

CHAPTER 4

RESULTS

The purpose of this descriptive, comparative study was to:

- 1) to investigate undergraduate nursing student perceptions of caring to determine if those students educated in a nursing curriculum that has caring theory incorporated as a primary focus within the curriculum framework within the U.S. differed from those students educated in a nursing curriculum that has general systems theory incorporated as a primary focus;
- 2) to investigate if there were differences in perceptions of caring by baccalaureate nursing students from schools with a caring framework in the U.S. and, schools in Thailand.

Watson's (1985) Caring Theory and the Carative Factors/Caritas Processes were used as a framework for study. In this chapter, the findings of the study are described.

First, the outcomes that resulted from an analysis of the participant demographic variables are identified. Next, findings relative to each of the research hypotheses are described.

1. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factory Survey-Care Provider Version (CFS-CPV).
 - a. There will be no difference between Southeastern and Thailand Care Groups' scores on the Caring Factor Survey-Care Provider Version (CFS-CPV).
2. Southeastern and Thailand Caring Groups will score higher than the Midwestern Systems Group on the Caring Factory Survey-Care for Self (CFS-CS).
 - a. There will be no difference between Southeastern and Thailand Care Groups' scores on the Caring Factor Survey-Care for Self (CFS-CS).

3. CFS-Care Provider and Care for Self total scores for the Southeastern, Midwestern, and Thailand schools will be significantly positively correlated.
4. Entry level students (freshmen and juniors) in the Thailand Caring Group will score higher than Thailand seniors on the Caring Factor Survey-Care Provider Version (CFS-CPV).
 - a. the Caring Factor Survey-Care Provider Version (CFS-CPV)
 - b. the Caring Factor Survey-Care for Self (CFS-CS)

Hypothesis 1 and 2 aimed directly at meeting the purposes of the study in identifying if there were differences in senior level baccalaureate nursing students perceptions of care for self and provision of care for others based on the type of curriculum (caring model or systems model) of their school of nursing and its location in the U.S. or in Thailand are addressed. Hypothesis 3 was related to Watson's belief that self-care is essential in providing care for others. For this reason, it was believed that senior nursing students who have high self-care perceptions will also have high perceptions of care provided to others. Finally, to provide a baseline, entry level Thai students were compared to Thai senior students (Hypothesis 4).

Also included is a summary of the open-ended question regarding what factors contributed to student responses on the Caring Factor Survey – Care of Self. Major themes are identified from all participants who responded to this question. Limitations to the study are presented.

Participants

A total of 696 questionnaires were distributed to participants with 591 (85%) returned. Of the returned questionnaires, 29 had missing data (4.9% of the data). Seven of the 29 surveys were totally blank resulting in 584 surveys used for analysis. Of the seven blank questionnaires, three were from the Midwestern school and two each from the Southeastern and Thailand school.

Since the remaining 22 questionnaires with missing data had less than half of the questionnaire not completed in either the CFS-CS or the CFS-CPV, these were included in the analysis. In Table 3 the numbers and percentages of participant questionnaire returns from which the sample was drawn are listed.

Table 3

Participant Questionnaire Return Rate

Student Year/ School	Seniors		Juniors		Sophomores		Freshmen	
	Distrib- uted	Returned	Distrib- uted	Returned	Distrib- uted	Returned	Distrib- uted	Returned
Midwest University	104	100 (96%)	75	59 (79%)	00	00	00	00
Southeast University	70	47 (67%)	33	25 (76%)	55	54 (98%)	55	54 (98%)
Thailand University	119	85 (71%)	120	100 (83%)	00	00	120	117 (98%)

Data labeled as freshmen and sophomore from the Southeast University Caring Group were not used in the analysis as originally planned for Hypothesis 4 since the intent was to compare students at the beginning of their nursing program rather than in their pre-nursing courses. Data from the junior level U.S. Schools were not used as entry level since that data were collected late in the junior year and could not be considered entry level. Therefore, only freshmen and junior data from the Thai Caring Group were used as entry level student analysis and Hypothesis 4 was amended to reflect this comparison.

Seniors across all programs were used for comparison between programs on the CFS-CPV and the CFS-CS. Only Thai students were used for entry level comparisons to address hypothesis four. The final sample consisted of seniors from the Southeastern School (47), Midwestern School (100), and Thailand (85). In addition, there were 100 junior and 120 freshmen from Thailand that were included in the sample as entry level students.

Demographic Findings

A total of 591 participant responses were received. Missing data varied from a low of 14 (2.4%) for class level and a high of 50 (8.5%) for socioeconomic status. Descriptive indexes for the demographic variables revealed significant differences for all variables when compared by setting (Midwest, Southeast, or Thailand school of nursing), except the status of the student in school (full or part time). Significance was identified if one group had a difference of more than 10%. Cross tabs and Pearson Chi square tests served to confirm the differences. Pearson Chi-Square results were .000 unless otherwise specified by demographic. The findings were drawn from frequency distribution tables that included both the count and percentages for each response.

As might be expected in the nursing population, the percent of female participants (93.2%) was significantly higher than male participants (6.8%) Although each school had only 13 male respondents, percentages varied. The school having the highest percent of males was in the southeast school (10.7%). The Thailand school had only 4.3% males and the Midwest school 8.4%. There was a significant association between gender and setting (Southeast, Midwestern, and Thailand School) $X^2(2) = 6.491, p < .039$.

The age of students ranged from the youngest at 17 years and the eldest at 57 years. Significant variation was found in age by school. The age range of students in the Midwestern

school was 17 to 54 with the majority of students (89%) between the ages of 20 and 29. The Southeastern school age range was 17 to 56. However, 70% were in the 20-29 age range, 18% in the 30-39 age range, and 7.5% over 40 years. The Thai participants were largely under 30 years with 74% of the participants in their 20's and 23% under 20 years of age. The oldest participant was 37 with only eight students in their 30's. Chi Square Tests showed a significant association between age and setting $X^2(70) = 244.404, p < .000$.

There was considerable variability in marital status and differences between participants by school. The largest percentages of participants were single with 96% (287 of 299) of the Thai students in this category. In the Midwestern school, 78.7% (122 of 155) of the participants were single; and, in the Southeastern school 52.9% (64 of 121). The Southeastern school's participants included 21.5% (26 of 121) married students; whereas, the Thai school had only 3% (9 of 299) married and the Midwestern school 12.3% (19 of 155). Only a small percentage of students in each school were widowed, divorced or separated. The highest number in these categories was in the Southeastern school with 10 students (8.3%) divorced. Chi-Square Tests indicated a significant association between marital status and setting $X^2(10) = 121.909, p < .000$. Post-hoc testing was completed for this variable.

Grade point average was widely dispersed from a low of 1.84 to a high of 4. Table 4 provides a summary of age and marital status by setting as well as overall grade point average for all students.

Variability was expected among the schools for race due to the inclusion of a non-U.S. school. The Thai population was comprised of 98.7% Asian students. Only 5.8% of the participants from the Southeastern school were Asian and 5.2% in the Midwestern school.

Table 4

Age, Marital Status, and Grade Point Average of Participants by Setting

		Setting						Total	
		Southeast		Midwest		Thailand			
		n	%	n	%	n	%		
Age	< 20 Years	2	2	1	0.7	69	23.75	72	12.7
	20-29 Years	84	70	136	89	214	73.5	434	77
	30-39 Years	22	18	13	8.5	8	2.75	43	7.5
	40-49 Years	9	7.5	1	0.7	0	0.0	10	2
	50 and above	3	2.5	2	1.1	0	0.0	5	.8
Total		120	100.0	153	100.0	291	100.0	564	100.0
		Setting						Total	
		Southeast		Midwest		Thailand			
		n	%	n	%	n	%		
Marital	Currently Married	26	21.5	19	12.3	9	3	54	9.4
	Widowed	0	0.0	0	0.0	1	0.3	1	0.2
	Divorced	10	8.3	3	1.9	0	0.0	4	2.3
	Separated	2	1.7	2	1.3	0	0.0	4	0.7
	Single	64	52.9	122	78.7	287	96	473	82.3
	Never Married	19	15.7	9	5.8	2	0.7	30	5.2
Total		121	100.0	155	100.0	299	100.0	575	100.0
		n	%						
Grade	1.84 - 2.49	54	11						
Point	2.50 – 2.99	124	26						
Average	3.00 – 3.49	99	20.5						
	3.50 – 4.00	201	42.5						
Total		482	100						

The Southeastern school had 60.8% of participants who were Caucasian compared to 88.9% (136 of 153) of participants in the Midwestern school. The Southeastern school included 14.2% (17) African Americans compared to 2.6% (4) in the Midwestern school. The Southeastern school also had 21 participants (17.5%) who were Hispanic/Latino compared to 3 (2%) from the Midwestern school. The Pearson Chi-Square Tests indicated a significant association between race and setting $X^2(10) = 577.251, p < .000$. The findings regarding ethnicity did not add any additional information to the data on race.

The majority of the participants from all three schools are full time and enrolled in a traditional program. Less than 1% of all students attend part time. The Pearson Chi-Square Tests indicated that there was no significant association between full time or part time study and setting $X^2(2) = .037, p < .982$. Variability was identified in type of student when compared by school. It was found that the Southeastern school had a large number of accelerated second degree students, 40 of 121 or 33% compared to 1.9% in the Midwestern school and no accelerated students in the Thai school. A little over 17% (29 of 155) of the Midwestern school students had a previous non-nursing degree; however, they were enrolled in a traditional program rather than accelerated. An additional 5% of the participants in the Southeastern school were in this category as well. Only 1.0% of all participants were in a LPN to BSN program and all attended the Midwestern school. When student type was compared with the setting, significant differences were found. The Pearson Chi-Square revealed a significant association between the type of student and setting $X^2(6) = 217.955, p < .000$.

In regard to employment, almost 76% of students in the Southeastern school are not employed in healthcare compared to 38.7% in the Midwestern school and 93.2% in the Thai school. Of those that are employed in healthcare in the Midwestern school, approximately 48%

are employed as nurse aids or technicians. Of those employed from the Southeastern school, only about 9% hold a nurse aid or technician position. Chi-Square tests identified a significant relationship between healthcare employment and setting $X^2(8) = 220.526, p < .000$.

There was high variability in income when analyzed for participants by school. Salary ranges were from less than \$10,000.00 to \$70,000 or more. There were large income differences between students in the Southeastern and Midwestern schools. 23-26% of the participants in each school earned more than \$70,000. Conversely, almost 27% of the Southeastern school participants earned under \$10,000 while almost 44% of the Midwestern school participants were in this category. Participants from the Thai school had lower incomes. Only 4.4% of these students earned in the \$70,000 or more range. Approximately 23% earned less than \$10,000.00 and 37% between \$10,000 and \$19,999. An additional 13.9% earned \$20,000-\$29,999. The Chi-Square tests for this category also indicated a significant relationship with setting $X^2(14) = 120.567, p .000$.

Participants were asked to identify religious affiliation selecting from Protestant Christian, Catholic, Jewish, Muslim, Hindu Buddhist, Christian Scientist, Mormon, none, or other. Protestant, Catholic, and Buddhist were selected for analysis due to the fact that all other selections had less than eight respondents.

Finally, participants were asked to identify the reason for attending their current school. This question was asked to determine primarily if participants selected the school based on the curriculum framework that focused on caring. Only two participants listed this as a reason. Participants could select more than one option. Reasons selected by study participants included: the reputation of the college or university; location; parent preference; cost of the program compared to others; reputation of the school of nursing; the type of nursing courses; where

friends were attending. The reputation of the college or university and the nursing school, parent preference, and location were the primary reasons for attendance.

Measures

To establish the internal consistency reliability of the Caring Factor Survey-Care Provider Version (CFS-CPV), the recommended Cronbach's alpha correlation of .800 was used (Field, 2009). The alpha correlation co-efficient for the all schools' CFS-CPV aggregate total scores was .90. The alpha coefficients by setting were: .928 for the Southeastern school, .933 for the Midwestern school, and .873 for the Thailand school. Adequate internal consistency also was demonstrated for the Caring Factor Survey-Care for Self (CFS-CS), with coefficient alphas for all schools' aggregate total scores = .894, for the Southeastern school = .895, for the Midwestern school = .833, and, for the Thailand school = .805. Internal consistency coefficients for these measures were consistently comparable (Herbst, 2012).

Hypotheses

The study focused on whether there is a difference in baccalaureate senior level nursing student perceptions of provider caring as well as self-care between students matriculating in schools/colleges in the U.S. that incorporate caring theories in their curriculum and those that incorporate systems theory. Inquiry also focused on whether there is a difference in perceptions of provider care and self-care between baccalaureate senior level nursing students that matriculate in schools/colleges in the U.S. that incorporate caring theory in their curriculum and those in Thailand. Table 5 provides a summary of the hypotheses testing results followed by further description of findings.

Table 5

Summary of Hypothesis Testing: Setting, Sample, Mean Score, Statistical Outcome, and Hypothesis Outcome

Hypotheses	Setting & n	Mean Score	SD	F statistic	df	Level of significance	Accept/reject hypothesis
1. Southeast Caring and Thailand Caring Groups will score higher than the Midwest Systems Group on the Caring Factory Survey-Care Provider Version. (CFS-CPV).	Southeast 40 Caring	6.14	.589	4.736	2,214	.010	Reject
a. There will be no difference between Southeastern and Thailand Care Groups' scores on the Caring Factor Survey-Care Provider Version (CFS-CPV).	Thailand 82 Caring	5.97	.511				Accept
	Midwest 90 Caring	6.23	.549				
2. Southeast Caring and Thailand Caring Groups will score higher than the Midwest Systems	Southeast 39 Caring	5.51	1.12	2.27	2,186	.107	Reject
	Thailand 60 Caring	5.79	.60				
	Midwest 90 Caring	5.83	.72				

Group on the Caring Accept

Factory Survey-Care for

Self (CFS-CS).

a. There will be no

difference between

Southeastern and

Thailand Care Groups'

scores on the Caring

Factor Survey-Care

Provider Version (CFS-

CPV).

3. Caring Factor Survey-	CPV	N=217	6.11	.58	Pearson	.000	Accept
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Care Provider Version	CS	N=179	5.75	.79	Correlat		
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(CFS-CPV) and Caring

Factor Survey-Care for

Self (CFS-CS) total scores

for Southeast, Midwest,

and Thailand Groups will

be significantly

positively correlated.

4. Freshmen and Juniors

will score higher than

Seniors in the Thailand

Group on:

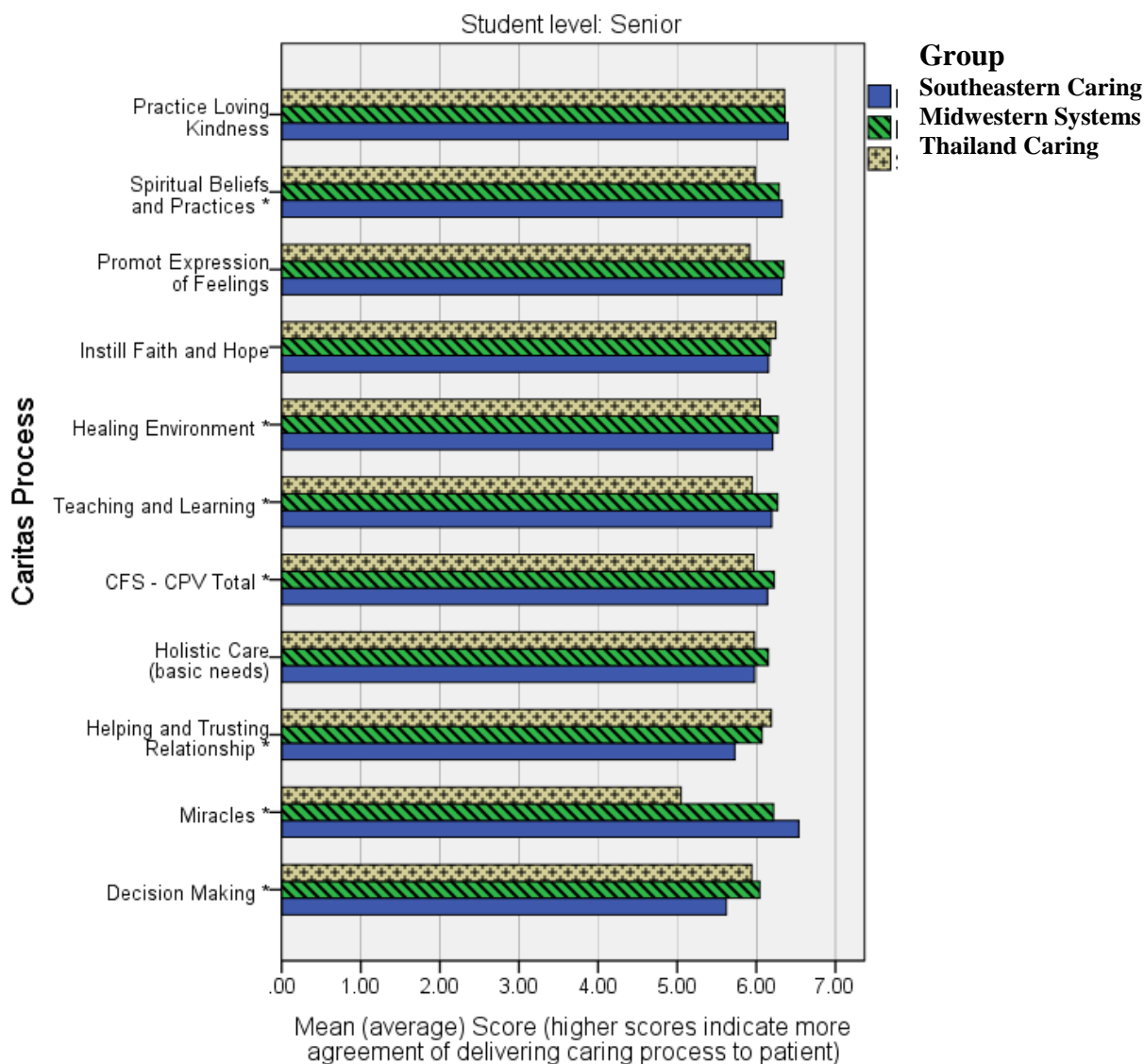
a.	the Caring	Freshmen	99	6.16	.38	2.91	3,281	.035	Accept
	Factor Survey-	Juniors	91	6.08	.47				
	Care Provider	Senior	83	5.98	.50				
	Version (CFS-								
	CPV), and								
b.	the Caring	Freshmen	76	6.13	.42	7.68	3,219	.000	Accept
	Factor Survey-	Juniors	76	6.13	.46				
	Care for Self	Senior	62	5.80	.58				
	(CFS-CS)								

Hypothesis 1.

Hypothesis 1 stated that senior students in the Southeast Caring Group and the Thailand Caring Group would score higher on the Caring Factor Survey-Care Provider (CFS-CPV) compared to senior students in Midwestern Systems Group. The main hypothesis as stated was not supported, while the sub-hypothesis that there would be no differences in scores of the two Caring groups on the CFS-CPV was supported. Figure 2 provides an overview of the CFS-CPV by study groups and includes the overall and dimensions scores of the instrument.

Figure 2

Descriptive Statistics for the CFS-CPV – Total and Dimension Scores by Study Groups



* Statistically significant difference using and alpha of .05

Hypothesis 1 stated: Southeast Caring and Thailand Caring Groups will score higher than the Midwest Systems Group on the Caring Factory Survey-Care Provider Version (CFS-CPV). The ANOVA resulted in the statistically significant mean differences among groups on the total CFS-CPV scores ($F = 4.736$; $df\ 2, 214$; $p = .010$). When post hoc LSD procedure was performed,

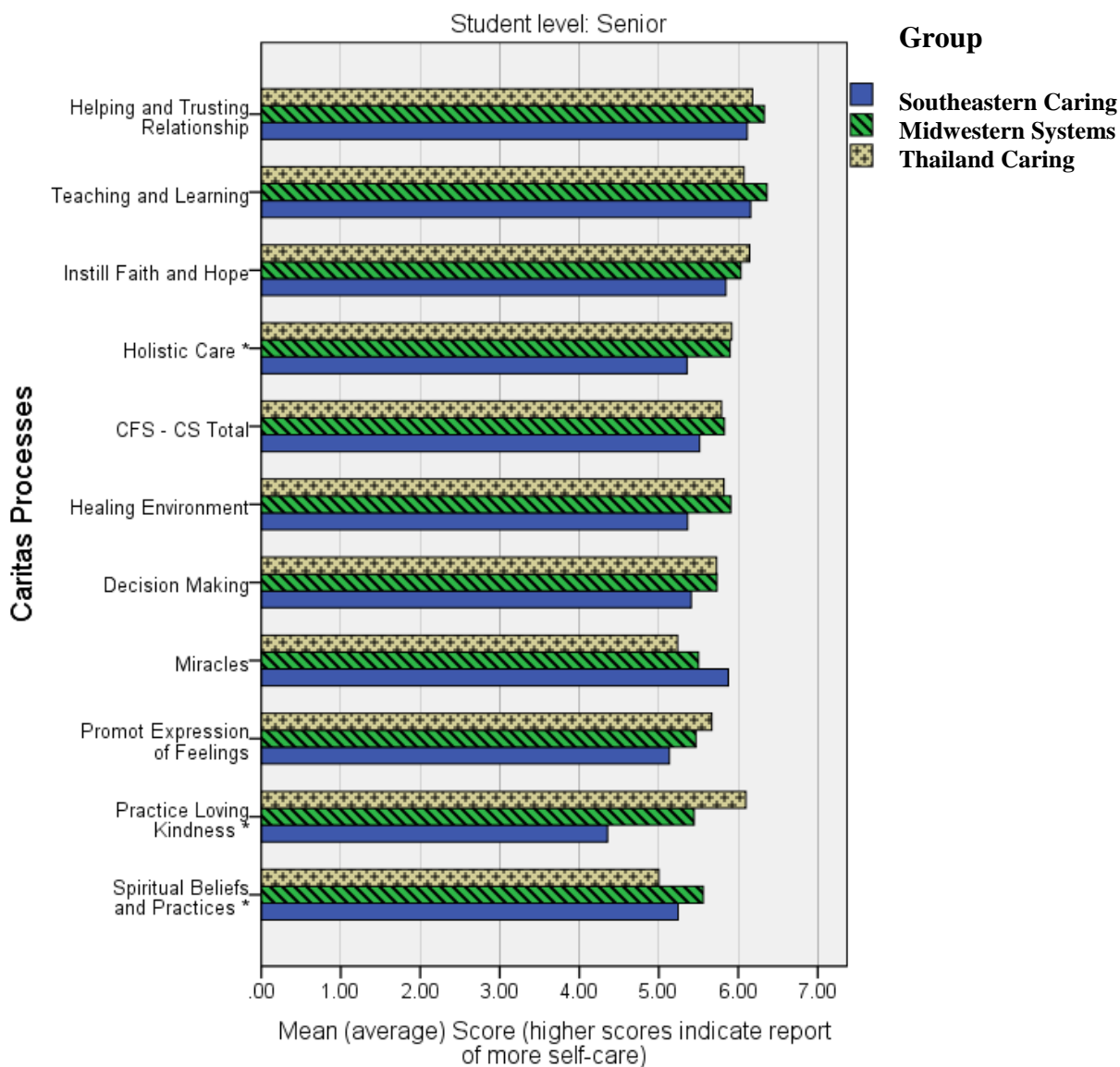
however, no statistical significant differences were found for caring groups scoring higher than the systems group; instead, statistical significance was attributed between the Thailand Caring and Midwestern Systems Groups ($p = .003$). The hypothesis was therefore rejected as stated, as the Midwest systems group scored higher ($m=6.23$, $sd=.549$) than both the Southeast Caring ($m=6.14$, $sd=.589$) and Thailand Caring ($m=5.97$, $sd=.511$) groups. When CPV subscales were compared, the Thailand Caring Group with the Midwestern Systems Group, statistical significance was identified for the following items: teaching and learning ($p = .002$); spiritual beliefs and practices ($p = .004$); healing environment ($p = .026$); promote expression of feelings ($p = .000$); and miracles ($p = .000$).

Hypothesis 2.

Hypothesis 2 stated: Southeast Caring and Thailand Caring Groups will score higher than the Midwest Systems Group on the Caring Factor Survey-Care for Self (CFS-CS). The ANOVA resulted in no statistically significant mean differences among groups on the total CFS-CS scores ($F = 2.27$; $df\ 2,186$; $p = .107$). The hypothesis was therefore rejected, with the Southeast Caring ($m=5.51$, $sd=.1.12$) and Thailand Caring ($m=5.79$, $sd=.60$), and Midwest systems groups ($m=5.83$, $sd=.72$) all scoring about the same. Hypothesis 2 sub-hypothesis stated: There will be no difference between Southeastern and Thailand Care Groups' scores on the Caring Factor Survey-Care for Self (CFS-CS). The ANOVA showed that the Southeast and Thailand Caring groups were not statistically different ($p=.090$); therefore, Hypothesis 2 sub-hypothesis was accepted. Figure 3 provides visualization for the descriptive statistics for the Caring Factor Survey-Care for Self (CFS-CS) total and subscales.

Figure 3

Descriptive Statistics for CFS-CS Total and Subscales by Group



* Statistically significant difference using an alpha of .05

Hypothesis 3.

The theory of caring science proposes that self-care is essential to providing effective care for others. This proposition formed the bases for Hypothesis 3: Caring Factor Survey-Care Provider Version (CFS-CPV) and Caring Factor Survey-Care for Self (CFS-CS) total scores for

Southeast, Midwest, and Thailand Groups will be significantly positively correlated. Pearson correlations for aggregate data for all groups were positively and significantly correlated ($r = .574, p = .000$) for CFS-CPV scores ($N = 217, M = 6.11, SD = .58$) and CFS-CS scores ($N = 179, M = 5.75, SD = .79$). Hypothesis 3, therefore, was accepted.

Hypothesis 4.

Hypothesis 4 stated: Freshmen and juniors will score higher than seniors in the Thailand Group on:

- a. the Caring Factor Survey-Care Provider Version (CFS-CPV), and
- b. the Caring Factor Survey-Care for Self (CFS-CS)

The ANOVA for hypothesis 4a resulted in the statistically significant mean differences among groups on the total CFS-CPV scores ($F = 2.91; df\ 3, 281; p = .035$). When post hoc LSD procedure was performed, statistical significance was attributed between the seniors and freshmen ($p = .005$). The hypothesis was therefore accepted as stated, as the freshmen scored higher ($m = 6.16, sd = .38$) than seniors ($m = 5.98, sd = .50$).

The ANOVA for H4b resulted in the statistically significant mean differences among groups on the total CFS-CS scores ($F = 7.68; df\ 3, 219; p = .000$). When post hoc LSD procedure was performed, statistical significance was attributed between the seniors and freshmen ($p = .000$). The hypothesis was therefore accepted as stated, as the freshmen scored higher ($m = 6.13, sd = .42$) than seniors ($m = 5.80, sd = .58$). For the Thailand school the hypotheses that freshmen students would score higher on the CFS-CS and the CFS-CPV were accepted.

Qualitative Comments

An open-ended question was included on the Caring Factor Survey – Care for Self (CFS-CS): “Please describe the attitude, behaviors and/or actions that led to your answers.”

Participants' qualitative responses were intended to offer insight into possible motivating factors for completing the questions in this instrument. Number and percentage of responses to this question on the Caring Factor Survey- Care for Self (CFS-CS) are provided in Table 6.

Table 6

Response Rates to Question on Motivations for Care of Self Answers by Level and Setting

Student Year/ School	Midwest			Southeast			Thailand		
	n	N	%	n	N	%	n	N	%
Seniors	60	98	61	22	46	48	20	96	21
Juniors							19	98	19
Sophomore									
Freshmen							52	117	44

Participants' responses were examined using the content analysis process recommended by Elo and Kyngas (2008). Verbatim responses were listed and sorted into similar content groups. Each content group was examined to assure assignment to the correct group. Then each content group verbatim comments were condensed to be described in a major theme inclusive of all content items. Seven major themes that emerged are listed as follows along with a verbatim example of each:

1. Positive attitude or respect toward self-care: A senior from the Midwestern School expressed; "I am very interested in caring for and knowing about myself."
2. Personal attributes: A senior from the Midwestern School stated; "I know who I am and am a happy individual."
3. Current intervening factors that decrease the ability to care for self: A senior from the

Southeastern School said; “Not having time to think about myself each day because I am too busy.”

4. External factors contributing to self-care such as family, friends, and life experience: A senior from the Southeastern University stated; “I try to immerse myself around people I like/love”.
5. Influence of faith, religion, and spirituality: A freshmen student from the Thailand school stated; “I believe in the Holy Spirit. The Holy help us in recovering from sickness to build the faith and morale to support our morale. I believe that all people are always living with hope, and have an opportunity to do what the best thing for lives.”
6. Personal philosophical statements (example): “A Senior Thailand student said; “We need to start loving ourselves first, then taking care of our own, together we think positively, whether we face on what kind of problem – we should solve the problem with consciousness and self-confidence.”
7. Lifestyle: A senior from the Midwestern University responded; “Eating healthy, exercise, and time for enjoyment.”

Limitations

The inability to obtain data for entry level nursing students at the Southeastern and Midwestern Schools posed a limitation to the study, which limited comparisons among senior, junior, and freshman students’ perception of caring behaviors to the Thailand School only (Hypothesis 4). Generalizations cannot be made to other nursing program settings due to notable differences across Schools, such as the demographic variables and differing school characteristics (size, program offerings, other non-caring curriculum frameworks). Though

statistical significance was not achieved, there was indication of approaching significance. A larger sample size would be needed to determine whether the findings would be replicated.

Findings for comparison of perceptions of care for others and care for self were drawn from the perceptions of entry level students with seniors enrolled in the 2011-2012 academic school year. While statistical significance was found, with entry level students having higher caring scores than seniors, caution is needed in drawing conclusions about this finding. A longitudinal study using the same participants during their entry year and senior year would provide more conclusive findings.

Recommendations for future study in Nursing Education are suggested in Chapter 5. The recommendations are made with the knowledge that there are limited numbers of U.S. schools based in caring theory as well as limited numbers of systems-based schools in Thailand.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents a discussion of the findings of the inquiry relative to senior level baccalaureate nursing students' perceptions of caring as influenced by curriculum focus. Theoretical perspectives and educational applications are discussed as well as the strengths and limitations of the study. Recommendations are made for future research.

Conclusions Based on Study Findings

The purpose of the research study was twofold. First, it was to investigate baccalaureate nursing student perceptions of caring to determine if there were differences between those students enrolled in a school setting where the concept of caring was a major focus compared to those enrolled in a school setting where caring was not the major focus of the curriculum. The second purpose was to investigate whether there were differences between baccalaureate students enrolled in a U.S. school with a curriculum focus of caring and students enrolled in a non-U.S. school. The study emerged from the investigator's experiences and questions about how nursing education programs prepare students for their professional role in caring for others. The investigator also was influenced by work with students in the clinical setting where current changes in the delivery of health and nursing services are affecting the nursing role. Additionally, need for the study arose from questions about the impact of changes in higher education that influence nursing education.

The sample consisted of nursing students enrolled in a baccalaureate nursing program in one of three schools of nursing: Southeastern, Thailand, and Midwestern Schools. Participants were in the senior year of their program at the three schools or were entry level students who had not yet enrolled in senior courses. The majority of students were female, enrolled as full time students, and not employed in health care. There was variability in age (from 17-24 years), type

of student (traditional or accelerated), grade point average, and socio-economic status across and within the schools. Over 50% were single and most held religious beliefs that were from a Protestant, Buddhist, or Catholic perspective. Analysis and post-hoc testing of demographics identified no statistical significance for these variables. These demographic findings were supportive in identifying that with apparent variability there is homogeneity.

Additional study could assist nurse educators to better understand students' perceptions that influence their learning processes. Questions that arise for further study include: Are there gender differences regarding understandings of caring and its expression in the clinical setting? How does age correlate with caring behaviors? How or does personal income influence caring behaviors? What is the relationship between religion and understanding of caring? How does length of time in a program of study relate to integration of the values of nursing, such as caring? What is the relationship of demographic variables to each other? In addition, study is needed of the effects of teaching strategies related to fostering an understanding of the concept of caring.

Hypothesis 1 was rejected, stating that Southeastern and Thailand Caring Groups would score higher than the Midwestern Systems Group on the Caring Factory Survey-Care Provider Version (CFS-CPV). Sub-hypothesis 1 was accepted stating that there would be no difference between Southeastern and Thailand Caring Groups' scores. Students from caring curriculum schools did not have higher scores than those from the systems curriculum; in fact, students from the systems curriculum scored significantly higher than the Thailand caring curriculum.

There is a limited body of knowledge to draw upon to understand the outcomes for this hypothesis. The investigator suggests further study specifically focusing on the basis of the student responses to question on the caring instruments. Possible areas of inquiry include what the student understands about the construct of caring and the motivating factors for answering

questions on the caring instruments. Recent discussion with Nelson (personal communication, 2012) generated dialog about whether lower scores of students in a caring curriculum relate to an enhanced clarity of understanding of the concept of caring as a result of their education; and, whether clarity about the construct may lead to a more accurate evaluation of their own attitudes and behaviors, thus resulting in lower caring scores. Thus, investigation of the concept of clarity as it relates to the concept of caring is recommended.

Another plausible rationale for the findings relates to the strong external influences that continue to pressure toward focus on the technical aspects of nursing and those factors that support a business-oriented model of care provision (Duffy, 2009; Patistea & Siamanta, 1999). These influences may have a stronger impact than that of curriculum on the behaviors of senior level nursing students. The study may not have identified all variables influencing caring scores, thus further study is warranted.

Hypothesis 2 was rejected stating that Southeastern Caring and Thailand Caring groups will score higher than Midwestern Systems group on the Caring Factor Survey-Care for Self (CFS-CS). Sub-hypothesis 2 was accepted stating that there would be no difference between Southeastern and Thailand Caring Groups' scores. As indicated in the findings, there was no statistical significance between the Southeastern Caring and Thailand Caring groups when compared to Midwestern Systems group. Again, there remains question as to factors leading to the result that there would be no differences in self-care behaviors for students in both a caring model school and a systems model schools. Are these results a function of the curriculum or stronger external factors such as expectations of their personal and work environment influencing self-care behavior is yet to be answered?

As with Hypothesis 1, the lack of difference between perceptions of students in caring and systems schools related to either self or other cannot be supported from the literature due to the absence of research in the area. Personal experience with nurses over 40 years informs this investigator that nurses do not possess good self-care behaviors often attributed to a high stress profession. The lack of difference in scores, particularly between the caring and systems schools may relate, at least in part, to the stresses of school that compound personal home stressors, and for some, employment commitments. The outcomes from testing this hypothesis may also relate to clarity in relation to self-care with scores being lower as a result of increased education about the care construct. Future qualitative studies in which students are asked about their responses may be helpful in future study to gain a better understanding of their perceptions.

As hypothesized, there was no statistically significant difference between the Southeastern and Thailand Caring Groups. No differences between Caring groups indicates that students from Caring curricula score similarly; however, the Midwestern systems students' mean scores were not significantly different from the Caring curricula students' scores. Lack of significant differences across schools could mean that curricula failed to impact students' perceptions of caring for self. Conversely, lack of significant differences across schools could mean that all curricula, regardless of theoretical basis, impacted students' self-care perceptions equally. Overall, the self-care scores were lower than care provider scores. Further study is suggested in the Recommendations for Future Study.

Hypothesis 3 stated that CFS-Care Provider and Care for Self total scores for the Southeastern, Midwestern, and Thailand schools would be significantly positively correlated. This hypothesis was drawn directly from the theoretical framework of caring in which higher self-care practices will provide higher levels of care to patients. Caring Science Model posits that

care for self is necessary to effectively care for others. Both CFS-Care Provider and Care for Self scales were found to have high internal consistency reliability providing for an equally reliable basis upon which to measure the relationship between the scales. The statistically significant Pearson's correlation provides evidence that substantiates the reciprocal relationship as depicted in the theoretical model (see page 62).

It is important to note that both CPV and CS measures originated in and have been used in studies of practicing nurses in a variety of settings (Herbert, 2011; Hozak & Brennan, 2011). Findings of this study using reliable caring measures attest to expanded generalizability to other related populations to which the caring concepts apply.

Hypothesis 4 stated that freshmen and juniors will score higher than seniors in the Thailand Group on: a) the Caring Factor Survey-Care Provider Version (CFS-CPV), and b) the Caring Factor Survey-Care for Self (CFS-CS). Sub-hypothesis 4a and 4b were both accepted stating that Thailand Caring Group freshman and juniors will score higher than seniors on the Caring Factory Survey-Care Provider Version (CFS-CPV). The investigator posed Hypothesis 4 to determine whether students' perceptions of caring upon beginning nursing school changed over time from start to finish of their program.

Literature support for the Hypothesis 4 came from a study in in which there was a statistically significant difference in the means in caring behaviors between first and third year students, with third year students scoring lower than first year students. The conclusion of the authors was that the education process itself reduced caring behaviors (Komorita, Doehring, and Hirschert, 1991). These authors (1991) assumed that the teaching of caring is a component of the nursing curriculum and that students in later years of the program have a more realistic

understanding of the concept of caring. In this study the hypothesis was upheld with freshmen scoring higher than both sophomores and seniors.

Possible reasons for the findings in Hypothesis 4 require further research. Is it that students have a rather naïve understanding of caring as they enter the program; and, as they develop clarity about the meaning of caring, it may be that they evaluate themselves more accurately resulting in lower care scores? It is plausible that a greater understanding of the concept of caring provides a more realistic basis for evaluating one's own caring behaviors from the perspective of the discipline. One wonders if the high ideals expressed about caring early in the program become mediated by the reality of the professional role as the student gains experience in the clinical setting throughout their program. In Chapters 1 and 2 support is provided from the literature regarding the effects of a focus on the technical aspects of nursing emphasized beginning with the publishing of the *Lysaught Report* that still exists today in the business-oriented orientation of the health care delivery system. Is this influence related to lower scores as students work within the healthcare delivery system? These are questions yet to be answered. Qualitative research could contribute to our understanding of this outcome. A longitudinal study is recommended to better assess the actual change occurring in perceptions over time by students upon entry to a nursing program, and, again at program completion.

A finding important to the study and relevant for future inquiry is that the instrument, the Caring Factor Survey – Care Provider Version (CFS-CPV) when used with students in this study had as equally strong reliability ($\alpha = .90$) as when it has been used with studies in the literature with nurses in a variety of settings (Herbert, 2011; Hozak & Brennan, 2011). Assessment of students using these instruments with undergraduate students is relatively new; thus, this finding is important to the continued development of the science. Equally as important is that the Caring

Factor Survey – Care for Self (CFS-CS) instrument also had strong reliability ($\alpha = .849$). In addition, the instruments are drawn directly from the Science of Caring (Watson, 1985) theoretical framework in which caring is specifically defined by specific *caritas* processes. The concept has been tested repeatedly and across cultures making the instruments strong for measuring caring.

The descriptive statistics for the CFS-CPV scores revealed relatively high average scores on each of the dimensions of the instrument for all participants. On a scale of 1-7, there were no mean scores below 5.0 indicating that participants view themselves as providing a high degree of caring as measured by the instrument. In most instances, the Thailand school participants recorded lower levels of caring. While the instruments had strong reliability as confirmed by a significant Cronbach's alpha correlation coefficient for students in all three settings, the researcher has questions about the effect of the students' view of self-evaluation and whether there may be a cultural effect. Nevertheless, it was heartening to the researcher that overall scores were toward more caring. It seems important that the additional question be asked about the patients' perception of the care that they are receiving from students as they prepare to enter the work setting. Power analysis should have been performed *apriori* for all procedures; but, considering the numbers of categories in each group, the power analysis would be the same.

The researcher gained some perspective on student scores by reviewing the responses to one open-ended question that asked for motivations, attitudes, and behaviors that contributed to their answering the CFS-CS questions. Their reflections revealed beliefs in their own goodness and the value of support from outside of themselves as well as a reflection of the struggles that challenge their goals. There were also comments about their desire to provide care for others. One student stated 'I try my best to care for myself so I can care for others.' Another student, in

responding to the same question, stated ‘I left a career making over \$100k because I no longer found the salary sufficient to justify having going to work.’

Implications for Nursing Education

The purpose of the study was a beginning effort at understanding senior level nursing students’ perception of caring as it relates to their nursing curriculum. It involved perceptions of care of self as well as care provided to others in their developing nursing role. The study assumed that caring is a universal concept; among U.S .and international students. The intent was to explore and describe these student perceptions and identify if there were differences based on the type of curriculum of their school, comparing a caring model curriculum with a systems model curriculum. The study has generated many more questions than it has answered, but it is a beginning to greater understanding about the concept of caring and the role of theoretically-based curricula in educating and socializing students to the professional role. Study findings have implications for nurse educators who pass on professional values and skills in supportive learning environments. Additionally nurse educators play a critical role in scientific inquiry and dissemination of the outcomes of their work.

Educators spend considerable time in the process of curriculum development that ranges from formulation of organizing frameworks from which content is arranged and classes are developed, to determining methodologies that are applied for the learning processes to occur. An organizing framework, centered on caring science, is relatively new. Models for creating and implementing nursing curricula with caring as the organizing framework are being developed (Hills & Watson, 2011). It is essential that there are methods in place for evaluation and research of this and other types of frameworks to assure the preservation of the values of the profession and the education of the graduate of tomorrow with these values. The study

investigated effects on students from the general perspective of curriculum as reflected in student perceptions of their own behaviors and attitudes about themselves and care provided to others because the desired effect from curriculum is change leading to socialization to the profession. The questions raised by this study challenge nurse educators to continue to examine curricular structures and to develop means for evaluation of outcomes in formal research. Examination of students' attitudes and perceptions over the course of their nursing programs can evaluate effectiveness of curricular designs.

A more specific implication for educators arising from this study relates to the conceptual relationship between care provision and self-care. The study demonstrated a strong positive relationship between care provision and self-care, which can challenge nursing educators to examine how they teach students personal self-care principles in relation to increased quality of patient care. Additionally, such examination may reveal that research is needed about how nursing faculty provide self-care for themselves and subsequently develop ways to model self-care to students.

Student comments to the open-ended question were insightful and contain fertile ground for future research relative to their own care as well as to how their attitudes and motivations impact their care for others. As indicated by the demographic data, further research is needed to understand the students who are coming into nursing. Study of student perceptions may assist in understanding the differences that occur from entry to graduation and what factors are contributing to changes in perception especially from freshmen to senior year.

Study of caring concepts is already being done world-wide with a focus on nurses in practice. It is important that the information gained from these studies be investigated for their relationship to a student population and the curriculum that prepares nurses for the profession.

Equally as important is the international study that helps to gain better understanding of caring as a universal concept.

Scholarly activity and research is a part of the role of faculty. It is important that quality research be conducted and that findings are disseminated so that through the sharing process, the science is further developed. In the practice arena, study of caring behaviors for self and others is already occurring from a global perspective. Collaboration between nurse educators and nurse clinicians can serve to bridge the gap in relationship building that has been identified in the literature. Joint follow-up studies between schools of nursing and practice settings where students are involved are important. The findings of these studies can be facilitative in understanding the longer term effects of students' learning and strengthening relationships between education and practice, which can in turn enhance student learning.

Recommendations for Future Research

Due to the limited research available on caring curricula and student attitudes and perceptions about caring behaviors, further inquiry is needed. While there is a great deal written about the concept of caring, little has been written about how or what type of curricula affect student socialization about caring. The major impetus for this study was to contribute to the knowledge of the science of caring as it relates to students and how they are socialized through the nursing curriculum regarding the value of caring. This investigator selected a quantitative approach for this study. However, many times throughout the study, the importance of qualitative research became evident. Actually talking with students and meeting with faculty and practice colleagues were recognized for future qualitative studies on caring. The outcomes from this study provide some basis from which further questions may be addressed with both qualitative and quantitative approaches.

Further research is indicated relative to the nursing curriculum and the students it serves. Research needs to focus on: 1) assessing various components of the caring curriculum model; 2) developing other valid and reliable measurement instruments for assessment of caring within nursing curriculums; 3) evaluating the perspectives of patients, educators, and nursing education administrators about student caring behaviors; 4) inquiring toward further understanding of the concept of caring in all of its dimensions; 5) better understanding student characteristics as they relate to socialization toward caring within their professional role; 6) incorporating the dimensions of caring with specificity within the curriculum; 7) identifying teaching strategies that promote positive caring outcomes; and 8) curriculum mapping to identify where the caring factors are in the curriculum; and 9) developing methods for evaluation of caring outcomes of the curriculum.

Those immersed in the study of Caring Science are developing reliable and valid measures for assessing perceptions of nurse manager's caring behaviors (Olendar & Phifer, 2012). In addition, measurement of caring is occurring in settings with a Relationship-Based Care Model of Practice (Persky, Felgen, & Nelson, 2012). Development of similar measurement instruments with psychometric testing is recommended that focuses on the caring behaviors of nurse educators and nurse administrators. Further work at determining best methods for assessment of caring curriculum frameworks could serve to inform nurse administrators of ways to strengthen caring curriculums.

Schools with curricula based on a model heavily focused on caring as the central concept are relatively new when compared with schools having traditional curricula, including the systems model. Given that most nurse educators' schools of origin were from a systems model, research

is needed to expand understanding faculty and nursing education administrators' perspectives on caring models.

Ultimately, a major goal in the socialization of baccalaureate students to nursing is the provision of safe, high quality nursing care that supports maximizing health of individuals and populations. Quality caring relationships between patients and nurses contribute to the healing process and overall health of persons. Research focused on the perception of patients about the caring received from students is also recommended.

The investigator recommends that student characteristics be examined more fully to determine which factors may be contributory to development in understanding of caring and which factors may pose as barriers. Examples for study might include the effects of age or religion. Questions such as: "How do perspectives on the dimensions of caring change with age?" "What is the relationship of age to type of self-care practices?" "What is the effect of religious beliefs on understanding of the concept of caring?" "How do religious beliefs affect self-care?" Additional questions might focus on "How is it that students come to know caring and to implement it in their professional role based on caring as defined in the science?"

Further study with greater numbers may reveal significance for the CFS-CPV and the CFS-CS total scores in which measure items could be studied in post hoc analyses to better understand dimensions related to the caritas processes. Additional inquiry for each measure's dimensions may be beneficial in understanding differences in student perspectives for these dimensions and how best to engage students in strengthening their caring practices. Caring, in the model used for the study is defined by ten dimensions. The instrument (CFS-CPV and CFS-CS) statements include questions to measure each of these ten dimensions. Data analysis outputs provide a total score for each of the instruments, but also provide information about the statistical significance

of each of the dimensions that define caring. More focused study of the dimensions may provide valuable information for teaching about care. For instance, one of the dimensions is ‘decision-making’. The statement to be evaluated by the participant on the CFS-CPV related to this dimension is: As a team, my colleagues and I are good at creative problem solving to meet the individual needs and request of our patients. On the CFS-CS questionnaire, the statement is: “I am creative at solving problems to meet my individual needs.” Discussion about creative problem solving, how students learn to creatively solve, and how it is taught has the potential for enhancing teaching about caring. Both quantitative and qualitative studies can help nursing educator develop rich and deep understanding of caring and how best to incorporate caring principles in curricula among many cultures.

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APPENDIX A

CARING FACTOR SURVEY – CARE PROVIDER VERSION (CFS-CPV) (ENGLISH)

Directions for the Senior Nursing Student:

This is a survey that measures your perception of the care you are providing for the patients under your care. It would be very helpful if you would respond to each of the 20 statements noted below about how you feel regarding the care you are currently providing to patients. The information that you provide by completing this survey will help us understand your perception of providing care more clearly. If you are able to respond to this brief survey, we thank you for your time and consideration. If you are not able to respond, we understand and respect your decision. If you do want to participate in this survey, please read the following instructions and respond to the 20 statements. If you have additional questions about the survey, or would like to know more about the results of this survey, you can contact: Connie Stopper at cstopper6@aol.com.

Thank you for your time and consideration in helping us understand the process of caring for patients!

Instructions: Please read each statement as it relates to you as a care provider to patients. For each question, you will be asked to indicate how much you agree or disagree with the statement. Please mark your responses by completely filling in the circle that best represents your opinion. For example, if you strongly agree with the statement you fill in the circle under “Strongly Agree”.

CARING FACTOR SURVEY – CARE PROVIDER VERSION (CFS-CPV)

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
1. Overall, the care I give is provided with loving kindness.						
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
2. I believe the healthcare team that I am currently working with solves unexpected problems really well.						
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
3. Every day that I provide patient care, I do so with loving kindness.						
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

<p>4. As a team, my colleagues and I are good at creative problem solving to meet the individual needs and request of our patients.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>5. The care I provide honors the patient's faith, instills hope, and respects the patient's belief system.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>6. When I teach patients something new, I teach in a way that they can understand.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>7. I help support the hope and faith of the patients I care for.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>8. I am responsive to my patients' readiness to learn when I teach them something new.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>9. I am very respectful of my patients' individual spiritual beliefs and practices.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>10. I create an environment for the patients I care for that helps them heal physically and spiritually.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>11. I encourage patients to practice their own individual spiritual beliefs as part of self-caring and healing.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>12. I work to create a healing environment that recognizes the patients' connection between body, mind, and spirit.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>

<p>13. I am able to establish a helping-trusting relationship with the patients I care for during their stay.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>14. I work to meet the physical needs as well as the emotional or spiritual needs of the patients I care for.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>15. Everybody on the healthcare team values relationships that are helpful and trusting.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>16. I respond to each patient as a whole person, helping to take care of all of their needs and concerns.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>17. I encourage patients to speak honestly about their feelings, no matter what those feelings are.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>18. If a patient told me that they believed in miracles, I would support them in this belief.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>19. Patients I care for can talk openly and honestly with me about their thoughts because I embrace their feelings, no matter what those feelings are.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>20. I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>

APPENDIX B

CARING FACTOR SURVEY – CARE PROVIDER VERSION (CFS-CPV) (THAI)

Directions for the Senior Nursing Student: (To be translated after committee approval)

This is a survey that measures your perception of the care you are providing for the patients under your care. It would be very helpful if you would respond to each of the 20 statements noted below about how you feel regarding the care you are currently providing to patients. The information that you provide by completing this survey will help us understand your perception of providing care more clearly. If you are able to respond to this brief survey, we thank you for your time and consideration. If you are not able to respond, we understand and respect your decision. If you do want to participate in this survey, please read the following instructions and respond to the 20 statements. If you have additional questions about the survey, or would like to know more about the results of this survey, you can contact: Connie Stopper at cstopper6@aol.com.

Thank you for your time and consideration in helping us understand the process of caring for patients!

Instructions: Please read each statement as it relates to you as a care provider to patients. For each question, you will be asked to indicate how much you agree or disagree with the statement. Please mark your responses by completely filling in the circle that best represents your opinion. For example, if you strongly agree with the statement you fill in the circle under “Strongly Agree”.

การสำรวจปัจจัยในการดูแล – ตามความคิดของผู้ให้บริการดูแลสุขภาพ

ไม่เห็นด้วย อย่างยิ่ง	ไม่เห็นด้วย	ไม่เห็นด้วย เล็กน้อย	เฉย ๆ	เห็นด้วย เล็กน้อย	เห็นด้วย	เห็นด้วย อย่างยิ่ง
1	2	3	4	5	6	7

<p>1. โดยทั่วไป ฉันให้บริการดูแลด้วยความรักและความเมตตา</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>2.</p> <p>ฉันเชื่อว่าคณะผู้ให้การดูแลด้านสุขภาพที่ฉันกำลังทำงานด้วยสามารถแก้ปัญหาที่ไม่คาดคิดได้เป็นอย่างดี</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>3. ฉันให้บริการดูแลผู้ป่วยทุกวัน ฉันทำด้วยความรักและความเมตตา</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>4. ในฐานะของการทำงานเป็นคณะ</p> <p>เพื่อนร่วมงานและฉันมีความชำนาญในการแก้ปัญหาอย่างสร้างสรรค์เพื่อตอบสนองให้ตรงตามความต้องการของแต่ละบุคคลและการร้องขอจากผู้ป่วยของเรา</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>5. ในการให้การดูแล ฉันให้เกียรติในความเชื่อของผู้ป่วย,</p> <p>การอยู่อย่างมีความหวังและเคารพในระบบความเชื่อของผู้ป่วย</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>6. เมื่อนั้นสอนสิ่งใหม่ๆ ให้ผู้ป่วย ฉันสอนด้วยวิธีที่ทำให้เขาสามารถเข้าใจ</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>

<p>7. ฉันช่วยสนับสนุนในความหวังและความศรัทธาของผู้ป่วยที่ฉันดูแล</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>8. ฉันตอบสนองต่อการเตรียมความพร้อมของผู้ป่วยของฉันเพื่อเรียนรู้เมื่อฉันสอนสิ่งใหม่ๆ ให้พวกเขา</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>9. ฉันเคารพอย่างมากในทางจิตวิญญาณในแต่ละบุคคลและการปฏิบัติของผู้ป่วยของฉัน</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>10. ฉันสร้างสิ่งแวดล้อมให้กับผู้ป่วยที่ฉันดูแลเพื่อช่วยรักษาสุขภาพทางร่างกายและจิตวิญญาณ</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>11. ฉันสนับสนุนผู้ป่วยให้ได้ปฏิบัติตามความเชื่อของตนเองทางด้านจิตวิญญาณให้เป็นส่วนหนึ่งของการดูแลตนเองและการรักษา</p> <p>1 0 2 0 3 0 4 0 5 0 6 0 7 0</p>
<p>12. ฉันทำงานเพื่อสร้างสิ่งแวดล้อมที่ช่วยในการรักษา</p> <p>โดยตระหนักถึงความสัมพันธ์ระหว่างร่างกาย จิตใจ และจิตวิญญาณของผู้ป่วย</p>

1 O	2 O	3 O	4 O	5 O	6 O	7 O
<p>13.</p> <p>ฉันสามารถที่จะสร้างความสัมพันธ์ที่ช่วยให้ความไว้วางใจกับผู้ป่วยที่ฉันให้การดูแลตลอดเวลาที่ผู้ป่วยรักษาอยู่</p>						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
<p>14. ฉันทำงานเพื่อตอบสนองความต้องการทางกายภาพเช่นเดียวกับความต้องการทางอารมณ์หรือจิตวิญญาณของผู้ป่วยที่ฉันดูแล</p>						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
<p>15. คณะผู้ให้บริการทางสุขภาพเห็นคุณค่าของความสัมพันธ์ที่เป็นประโยชน์และให้ความไว้วางใจ</p>						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
<p>16. ฉันตอบสนองต่อผู้ป่วยแต่ละรายว่าเป็นบุคคลทั้งคน เพื่อช่วยดูแลทุกความต้องการและความกังวลของพวกเขา</p>						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
<p>17. ฉันสนับสนุนผู้ป่วยให้พูดถึงความรู้สึกที่แท้จริงของตัวเอง ไม่ว่าความรู้สึกเหล่านั้นจะเป็นอย่างไร</p>						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
<p>18. ถ้าผู้ป่วยบอกว่าพวกเขาเชื่อในปาฏิหาริย์ ฉันจะสนับสนุนพวกเขาในความเชื่อเหล่านี้</p>						
1 O	2 O	3 O	4 O	5 O	6 O	7 O

19. ผู้ป่วยที่ฉันดูแลสามารถพูดกับฉันได้อย่างเปิดเผยและตรงไปตรงมาเกี่ยวกับความคิดของเขา

เพราะฉันเปิดแขนยอมรับความรู้สึกของเขาไม่ว่าความรู้สึกเหล่านั้นจะเป็นอะไร

1 0 2 0 3 0 4 0 5 0 6 0 7 0

20. ฉันยอมรับและสนับสนุนความเชื่อของผู้ป่วยเกี่ยวกับพลังของสิ่งศักดิ์สิทธิ์หากพวกเขาเชื่อว่าจะช่วยในการรักษา

1 0 2 0 3 0 4 0 5 0 6 0 7 0

APPENDIX C

CARING FACTOR SURVEY – CARE OF SELF (CFS-CS) (ENGLISH VERSION)

Directions to student: This is a survey that measures your perception of care for yourself. It would be very helpful if you would respond to each of the 10 statements noted below about how you feel regarding the care you are currently providing for yourself. In healthcare, employees spend a great deal of time and effort taking care of others but we do not know how much time employees spend taking care of themselves within their lives. The information you provide by completing the survey will help us understand the extent that you, as a nursing student, take care of yourself. Within the theory of caring as proposed by Watson, caring for others begins by caring for self and we would like to know how you are doing in this respect. If you are able to respond to this brief survey, we thank you for your time and consideration. If you are unable to respond, we understand and respect your decision.

If you do want to participate in this survey, please read the following instructions and respond to the 10 statements. If you have additional questions about the survey, or would like to know about the results of this survey, you can contact Connie Stopper at cstopper@kent.edu.

Thank you for your time and consideration in helping with this important work!

Instructions: Please read each statement as it relates to your self-care. For each question, you will be asked to indicate how much you agree or disagree with the statement. Please mark your responses by completely filling in the circle that best represents your opinion in the example below. If you strongly agree with the statement, you fill in the circle under “Strongly Agree.”

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree							
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7							
1. Everyday I care for myself with loving kindness.													
1	O	2	O	3	O	4	O	5	O	6	O	7	O
2. I am creative at solving problems to meet my individual needs.													
1	O	2	O	3	O	4	O	5	O	6	O	7	O
3. I honor my own faith, instill hope, and respect my belief system as part of my self-care .													
1	O	2	O	3	O	4	O	5	O	6	O	7	O

4. I value opportunities that allow me to increase my knowledge and understanding about myself .
1 O 2 O 3 O 4 O 5 O 6 O 7 O
5. I take time to practice my own individual spiritual beliefs as part of my self-caring and healing
1 O 2 O 3 O 4 O 5 O 6 O 7 O
6. I appreciate myself as a whole person and seek to take care of all of my needs and concerns .
1 O 2 O 3 O 4 O 5 O 6 O 7 O
7. I have established helping and trusting relationships
1 O 2 O 3 O 4 O 5 O 6 O 7 O
8. It is important for me to create a healing environment around me that recognizes the connection between mind and spirit.
2 O 2 O 3 O 4 O 5 O 6 O 7 O
9. I am able to evaluate my thoughts openly and honestly no matter what my feelings are because I embrace every aspect of who I am.
1 O 2 O 3 O 4 O 5 O 6 O 7 O
10. I accept and support my own current beliefs in a higher power which allows for me to heal (Do not respond to this statement if you feel spiritual beliefs are too personal)
1 O 2 O 3 O 4 O 5 O 6 O 7 O
11. Please describe the attitude, behaviors and/or actions that led to your answers.

APPENDIX D

CARING FACTOR SURVEY – CARE OF SELF (CFS-CS) (THAI VERSION)

การสำรวจปัจจัยการดูแล -- การดูแลตนเอง (CFS - CS) ©

คำชี้แจงสำหรับนักเรียน : นี่คือการสำรวจเพื่อวัดการรับรู้ของการดูแลตัวเองของท่าน

มันจะเป็นประโยชน์มากหากท่านจะตอบข้อคำถามทั้ง 10

ข้อด้านล่างนี้เกี่ยวกับว่าความรู้สึกในการดูแลที่ท่านกำลังให้สำหรับตัวท่านเอง

ในการดูแลสุขภาพคนใช้เวลาอย่างมากมายและใช้ความพยายามในการดูแลของตัวเองภายในช่วงชีวิตของพวกเขา

ข้อมูลที่ท่านให้โดยการกรอกแบบสำรวจนี้จะช่วยให้ผู้วิจัยเข้าใจในฐานะที่ท่านเป็นนักเรียน,

ดูแลตัวเอง ภายในทฤษฎีของการดูแลที่เสนอโดย วัดสัน

การดูแลผู้อื่นจะเริ่มมาจากการดูแลตัวเองและเราต้องการทราบว่าท่านกำลังทำในส่วนนี้อย่างไร

หากท่านสามารถที่จะตอบการสำรวจอย่างสั้น ๆ นี้

เราขอขอบคุณสำหรับเวลาและการพิจารณาของท่าน หากไม่สามารถตอบได้

เราเข้าใจและเคารพในการตัดสินใจของท่าน

หากท่านต้องการมีส่วนร่วมในการสำรวจครั้งนี้โปรดอ่านคำแนะนำต่อไปนี้และตอบข้อคำถาม 10

ข้อ หากท่าน

มีคำถามเพิ่มเติมเกี่ยวกับการสำรวจหรือต้องการทราบเกี่ยวกับผลการสำรวจนี้ท่านสามารถติดต่อ

Connie Stopper ที่ cstopper6@aol.com.

ขอขอบคุณสำหรับเวลาและการพิจารณาของท่านในการช่วยงานที่สำคัญนี้

คำแนะนำ : กรุณาอ่านคำชี้แจงในแต่ละคำถามเป็นที่เกี่ยวกับการดูแลตนเองของท่าน

สำหรับข้อคำถามแต่ละข้อ

ท่านจะถูกถามเพื่อให้ท่านแสดงปริมาณความเห็นด้วยหรือไม่เห็นด้วยกับคำถาม

โปรดทำเครื่องหมายคำตอบของท่านให้สมบูรณ์ในการระบายวงกลมที่แสดงถึงความเห็นที่ดีที่สุดของ
ท่าน ในตัวอย่างด้านล่างหากท่านเห็นด้วยอย่างยิ่งกับข้อคำถาม ท่านระบายในวงกลมภายใต้
"เห็นด้วยอย่างยิ่ง"

ไม่เห็นด้วย อย่างยิ่ง	ไม่เห็นด้วย	ไม่เห็นด้วย เล็กน้อย	เฉย ๆ	เห็นด้วย เล็กน้อย	เห็นด้วย	เห็นด้วย อย่างยิ่ง
1	2	3	4	5	6	7
1. ทุกๆวันฉันดูแลตัวเองด้วยความรักและความเมตตา						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
2. ฉันใช้ความคิดสร้างสรรค์ในการแก้ปัญหาเพื่อตอบสนองความต้องการส่วนตัวของฉัน						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
3. ฉันเคารพในความเชื่อของตัวเอง สร้างความหวัง และความเคารพระบบความเชื่อของฉัน ซึ่งเป็นส่วนหนึ่งของการดูแลตัวเองของฉัน						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
4. ฉันเห็นค่าของโอกาสที่อนุญาตให้ฉันในการเพิ่มความรู้และความเข้าใจเกี่ยวกับตัวฉันเอง						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
5. ฉันใช้เวลาในการปฏิบัติตามความเชื่อส่วนตัวทางจิตวิญญาณของฉันซึ่งเป็นส่วนหนึ่งของการดูแลตนเองของฉันและการรักษา (ไม่ต้องตอบข้อคำถามนี้ถ้าท่านรู้สึกว่าการเชื่อทางจิตวิญญาณเป็นเรื่องส่วนบุคคลเกินไป)						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
6. ฉันขอขอบคุณตัวเองในความเป็นบุคคลทั้งคนและหาทางที่จะดูแลทุกความต้องการและความกังวลของฉัน						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
7. ฉันสร้างการช่วยเหลือและความสัมพันธ์ที่ไว้วางใจ						
1 O	2 O	3 O	4 O	5 O	6 O	7 O
8. มันเป็นสิ่งสำคัญสำหรับฉันในการสร้างสภาพแวดล้อมในการรักษารอบ ๆ ตัวฉันที่ตระหนักถึงความสัมพันธ์ระหว่างจิตใจและจิตวิญญาณ						
1 O	2 O	3 O	4 O	5 O	6 O	7 O

<p>9. ฉันสามารถที่จะประเมินความคิดของฉันอย่างเปิดเผยและตรงไปตรงมาไม่ว่าความรู้สึกของฉันจะเป็นอะไรเพราะฉันเปิดแขนยอมรับในทุกแง่มุมที่ฉันเป็น</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>10. ฉันยอมรับและสนับสนุนความเชื่อของตัวเองในพลังของสิ่งศักดิ์สิทธิ์ ซึ่งจะช่วยฉันในการรักษา (ไม่ต้องตอบข้อคำถามนี้ถ้าท่านรู้สึกว่าความเชื่อทางจิตวิญญาณเป็นเรื่องส่วนบุคคลเกินไป)</p> <p>1 O 2 O 3 O 4 O 5 O 6 O 7 O</p>
<p>11. กรุณาอธิบายถึงทัศนคติพฤติกรรมและ / หรือการกระทำที่นำไปสู่คำตอบของท่าน</p>

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE (ENGLISH)

Directions: Provide a response to each of the questions below by filling in the appropriate circle and printing in answers as indicated.

Date: ____/____/2011_____

1. Gender: What is your sex?
 - ☐ Male
 - ☐ Female
2. Age: In what year were you born? _____
- 3 Marital Status: What is your marital status?
 - ☐ Currently married
 - ☐ Widowed
 - ☐ Divorced
 - ☐ Separated
 - ☐ Single, Never married
1. Race: Please specify your race.
 - ☐ American Indian or Alaska Native
 - ☐ Asian
 - ☐ Black or African American
 - ☐ Hispanic/Latino
 - ☐ Native Hawaiian or Other Pacific Islander
 - ☐ White/Caucasian
2. Ethnicity: Please specific your ethnicity.
 - ☐ Hispanic or Latino
 - ☐ Not Hispanic of Latino
3. Program: Select the name of your nursing program.
 - ☐ North Central Florida
 - ☐ Saint Louis College
 - ☐ University of Kansas
4. Class Level: Indicate whether you are a first year or senior year nursing student.
 - ☐ Junior year in the nursing program in the nursing during the 2011-2012 academic year
 - ☐ Senior year in the nursing program, graduating during the 2011-2012 academic year
 - ☐ Freshman year in the nursing program in Thailand

5. Full or Part-time status: Indicate whether you attend school full time or part time.
- ☐ Full time student (12 or more hours of coursework/semester)
 - ☐ Part time student (Less than 12 hours of coursework/semester)
6. Type of Student: Indicate your student status.
- ☐ Traditional student (having no previous college degree)
 - ☐ LPN to BSN
 - ☐ Accelerated Second Degree
 - ☐ Other (Specify) _____
7. Healthcare Employment status: Which statement best indicates your employment status in healthcare?
- ☐ Not employed in healthcare
 - ☐ Licensed practical nurse
 - ☐ Nurse aid or nurse technician
 - ☐ Senior nursing technician
 - ☐ Other (please specify) _____
8. Religious affiliation: What is your religious affiliation?
- ☐ Protestant Christian
 - ☐ Roman Catholic
 - ☐ Evangelical Christian
 - ☐ Jewish
 - ☐ Muslim
 - ☐ Hindu
 - ☐ Buddhist
 - ☐ Christian Scientist
 - ☐ Seventh-Day Adventist
 - ☐ Mormon
 - ☐ None
 - ☐ Other (Specify) _____
9. Socio-economic state: What is your yearly household income?
- | | |
|--|--|
| <input type="radio"/> Less than \$10,000 | <input type="radio"/> \$40,000 to \$49,999 |
| <input type="radio"/> \$10,000 to \$19,999 | <input type="radio"/> \$50,000 to \$59,999 |
| <input type="radio"/> \$20,000 to \$29,999 | <input type="radio"/> \$60,000 to \$69,999 |
| <input type="radio"/> \$30,000 to \$39,999 | <input type="radio"/> \$70,000 or more |

10. Your reason for choosing to attend your School of Nursing (Check all that apply).

- ☐ Reputation of the School
 - ☐ Location
 - ☐ My parents wanted me to attend this school
 - ☐ It is where my friends were going to school
 - ☐ Cost of the program compared to the cost of other programs
 - ☐ The campus facilities
 - ☐ The high reputation of the nursing program
 - ☐ The type of nursing courses in the program
 - ☐ Other (Please List)
-

11. What is your current Grade Point Average? _____

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE (THAI)

ID _____

แบบสอบถามข้อมูลทั่วไป

คำชี้แจง โปรดเติมคำหรือข้อความลงในช่องว่าง หรือทำเครื่องหมายกากบาท **x** ลงในช่องวงกลม **O**

หน้าข้อความที่ตรงกับข้อมูลของท่านให้ครบทุกคำถาม

ที่ที่ตอบแบบสอบถาม วันที่ (dd) _____ เดือน [กรุณาระบุเป็นตัวเลข (mm)] _____ ปี 2555

1. เพศ

- ☐ ชาย
☐

2. าย กรุณาระบุปี พ.ศ. (B.C.) ที่เกิด _____

3. สถานภาพสมรส

- ☐ ่า
☐ มาย
☐ หยารา
☐ ย ย
☐ โสด ย ม ยา

4. เช่ ซา

- ☐ ซนพื้นเมือง เมร ร ซนพ เม แถบาสา
☐ เช่ ย (ไทย ล่าว พม่า เวียดนาม หรืออื่นๆ)
☐ ผิดดำ หรือ ร เมร
☐ สเปนที่ม่ำจำกอเมรกำได้ หรือำ อเมรกำ
☐ ซนพ เม บนหมู่เกาะฮายา ร หมู่เ
☐ ่า ID _____

5. ชำติพันธุ์

- ☐ สเปนที่มาจากรอเมริกาใต้ หรืออ อเมริกา
- ☐ ม ไซ สเปนที่มาจากรอเมริกาใต้ หรืออ อเมริกา

6. สถาบันการศึกษาของท่าน คือ

- ☐ นอร์ทเซ็นทรัล ร ดา (North Central Florida)
- ☐ ยา ย เยส ประเทศไทย
- ☐ มหาวิทยาลัยแคนซัส (University of Kansas)

7. ท่านเป็นนักศึกษาชั้นปีอะไร

- ☐ เป็นนักศึกษาพยาบาล ชั้น ที่ 3
- ☐ เป็นนักศึกษาพยาบาล ชั้น ที่ 4
- ☐ เป็นนักศึกษาพยาบาล ชั้น ที่ 1

8. สถานภาพนักศึกษาของท่านจัดอยู่ในประเภทใด

- ☐ ศา เมเว (Full time) (ลงทะเบียนเรียน 12 หน่วยกิตหรือมากกว่า ต่อภาคการศึกษาปกติ)
- ☐ ศา Part time (ลงทะเบียนเรียนน้อยกว่า 12 หน่วยกิต ต่อภาคการศึกษาปกติ)

9. ท่านเป็น ศาหลักสูตรใด

- ☐ หลักสูตรพยาบาลศาสตรบัณฑิตภาคปกติ (ม มีวุฒิการศาร ด รามา
- ☐ หลักสูตรพยาบาลศาสตรบัณฑิต (ต่อเนื่อง 2 ปี) (พยาา เค็กษาต่อ พยาา ซาซ พ)
- ☐ ส รพยาบาลศาสตรแบบเร่งรัด (โดยการเทียบโอนวิชาจาก ร่ำล่ำซำอื่น)
- ☐ หลักสูตร โปรตร _____

10. สถานารรา ของท่านไ ร บริการส ภาพ ณ ขณะนี้ คือ

- ☐ ยัง ม ดาา ไ ร บริการส ภาพ (สธำนะภาพนักศึกษา)
- ☐ พยาา เทคนิค
- ☐ ซ ยเหลือผู้ป่วย (Nurse Aid)

- ☐ ผู้ช่วยพยาบาล
- ☐ ตำแหน่ง (โรค) _____ ID _____

11. ท่านนับถือศาสนา ร

- ☐ ร ส ยายโรส
- ☐ ร ส ยายโรมา
- ☐ สหกิจคริสเตียน (กลุ่ม ร ส ย ที่ยึดมั่นตามหลักคำสอนในพระคัมภีร์ใหม่)
- ☐ คำสอนาย
- ☐ ม ส ม
- ☐ ฮ ด
- ☐ พ
- ☐ ร ส เตียน ยา ศาส ร
- ☐ คริสเตียนนิกายเซเวนเดย์ แอ็ดเวนติส
- ☐ คริสเตียนนิกายม ร ม
- ☐ ไม่นับถือคำสอนใดๆ
- ☐ โปรตร

12. ร ร ของท่านมีราย ด ต่อเดือนเท่าไร

- ☐ ย 10,000 ๑ ☐ 40,000 - 49,999 ๑
- ☐ 10,000 - 19,999 ๑ ☐ 50,000 - 59,999 ๑
- ☐ 20,000 - 29,999 ๑ ☐ 60,000 - 69,999 ๑
- ☐ 30,000 - 39,999 ๑ ☐ ตั้งแต่ 70,000 บาทขึ้นไป

13. เใดบ้างที่ทำให้ท่าน เามาศึกษาในสถาบันพยาบาล แห่งนี้ (ได้มากกว่าหนึ่งข้อ)

- ☐ ช เส ย สถาบัน
- ☐ สธ
- ☐ ตามความประสงค์ของพ ม
- ☐ เสถาบันที่มีเพ มาเร ย ด้วยกัน
- ☐ ำชาย เมา ชาย หลักสูตร

- ☐ สยามสด ภายไมา ยาย
- ☐ ช เสี ย หลักสูตรราราพยา
- ☐ ความหลักนล่าย ส ราราพยา
- ☐ โรดระบุ) _____

14. เรดเย ทำน คือ _____

APPENDIX G

DIRECTIONS FOR ENTRY LEVEL NURSING STUDENT QUESTIONNAIRE (ENGLISH)

Directions for the Junior Year Nursing Student:

This is a survey that measures your perception of the care you believe you will provide for the patients who would be under your care. It would be very helpful if you would respond to each of the 20 statements noted below about how you feel regarding the care you believe you will provide to patients. The information that you provide by completing this survey will help us understand your perception of providing care more clearly. If you are able to respond to this brief survey, we thank you for your time and consideration. If you are not able to respond, we understand and respect your decision. If you do want to participate in this survey, please read the following instructions and respond to the 20 statements. If you have additional questions about the survey, or would like to know more about the results of this survey, you can contact: Connie Stopper at cstopper6@aol.com.

Thank you for your time and consideration in helping us understand the process of caring for patients!

Instructions: Please read each statement as it relates to you as a future care provider to patients. For each question, you will be asked to indicate how much you agree or disagree with the statement. Please mark your responses by completely filling in the circle that best represents your opinion. For example, if you strongly agree with the statement you fill in the circle under "Strongly Agree".

APPENDIX H

DIRECTIONS FOR ENTRY LEVEL NURSING STUDENT QUESTIONNAIRE (THAI)

Directions for the Freshman and Junior Year Nursing Student: (To be translated following committee approval)

This is a survey that measures your perception of the care you believe you will provide for the patients who would be under your care. It would be very helpful if you would respond to each of the 20 statements noted below about how you feel regarding the care you believe you will provide to patients. The information that you provide by completing this survey will help us understand your perception of providing care more clearly. If you are able to respond to this brief survey, we thank you for your time and consideration. If you are not able to respond, we understand and respect your decision. If you do want to participate in this survey, please read the following instructions and respond to the 20 statements. If you have additional questions about the survey, or would like to know more about the results of this survey, you can contact: Connie Stopper at cstopper6@aol.com.

Thank you for your time and consideration in helping us understand the process of caring for patients!

Instructions: Please read each statement as it relates to you as a future care provider to patients. For each question, you will be asked to indicate how much you agree or disagree with the statement. Please mark your responses by completely filling in the circle that best represents your opinion. For example, if you strongly agree with the statement you fill in the circle under "Strongly Agree".

APPENDIX I

CURRICULUM ANALYSIS FOR THE CONCEPT OF CARING

Table I							
Curriculum Analysis for the Concept of Caring							
School/College	Vision	Mission	Philosophy	Baccalaureate Program Objectives	Course Syllabi	Catalog	
Florida North Atlantic	5	5	5	5	4	5	Uses Caring
University of Kansas	NA	1	2	1	1	1	Uses Systems
Saint Louis College	NA	NA	4	4	5	NA	Uses Caring and Holism.

1 2 3 4 5

- 1: Concepts other than caring are listed and described
- 2: Occasional mention of caring within a framework other than caring (e.g. Systems theory)
- 3 Caring is present as a concept but inconsistently identified
- 4 Caring is evident as one of several concepts of the identified document
- 5 Caring is evident as the central concept of the identified document

NA – Document Not Identified

Examples of Supporting Evidence From Documents Reviewed:

Florida Atlantic University – Christine E. Lynne College of Nursing

Vision: To advance the body of caring knowledge in nursing through education, practice, research, and scholarship to transform care locally, nationally and globally.

Mission: Innovative approaches to nursing education within a caring philosophy; knowing self, students and colleagues as caring persons; understanding of caring as unique in nursing; creating a context for learning that respects, nurtures and celebrates the interconnectedness of person and environment.

Philosophy: Nursing is a discipline of knowledge and a field of professional practice grounded in caring. Scholarship and practice in nursing require creative integration of multiple ways of knowing. Nursing makes a unique contribution because of its special focus: nurturing the wholeness of persons and environment through caring. Caring in nursing is a mutual human process in which the nurse artistically responds with authentic presence to calls from clients. The experience of nursing takes place in nursing situations: lived experiences in which the caring between the nurse and client fosters well-being within a co-creative experience. Nurses participate with members of other disciplines to advance human understanding to enhance personal and societal living within a global environment.

Undergraduate Program Objectives: Be a generalist in nursing practice.

- Demonstrate an understanding of the complexity of caring through social-cultural responsibility and accountability as a member of the nursing profession.
- Create caring-healing environments through personal and professional leadership.

Course Outlines:

Being Cared For: Reflections from the Other Side of the Bed (NSP 1195) 3 credits

Writing Across Curriculum (Gordon Rule)

Prerequisite: ENC 1101

Exploration through writing, reading, and thinking about the concept “being cared for and its meaning to the individual as a member of society as well as a future health care professional. Course encompasses a variety of writing assignments based on readings and reflections on the situation of being nursed. This is a General Education course

Nursing Situations with Students in Schools (NSP 4856) 3 credits

Study of the professional practice of nursing in schools beginning with an historical overview, statutory guidelines, and standards of practice. Emphasis is on the various and complex dimensions of nursing practice focused on caring for students in the school setting

Introduction to Nursing as a Discipline and Profession (NUR 3115) 3 credits

An introduction to Nursing as a distinct discipline of knowledge and a unique professional service. Concepts introduced in this course are foundational to the program and include: Images of the nurse and nursing, nursing as a discipline of knowledge, nursing as a profession, wholeness of persons connected with others and with the environment, and nursing as nurturing the wholeness of persons through caring.

University of Kansas - School of Nursing

Mission: The University of Kansas School of Nursing is committed to educating students for diverse and changing roles as clinicians, teachers, researchers and leaders; generating new knowledge for nursing practice; and using our expertise in service to the global community.

Philosophy: A modified systems theory is used as the organizing framework for the construction and implementation of the nursing curricula. Four major concepts with definitional statements and sub-concepts, comprise the elements of the system. The major concepts are client systems, environment, health and nursing.

The major concepts are client systems, health, environment, and nursing. Caring is mentioned under nursing and under professional values as indicated: “The faculty of the School of Nursing recognize two interrelated aspects of professional practice: the art and the science of nursing. The art of nursing involves intuition, creativity, caring and application of nursing therapeutics, communication skills, and supportive interpersonal processes” and “Example concepts include the following: the art of caring; collegial relationships including language differences among professions; communication, including interpersonal, written, oral, and electronic; professional development including continuing education, certification, legal and ethical issues, leadership and management, standards of practice; professional roles; trends; governance; cultural competence.” (Approved 12/16/94; Implementation date: Fall, 1995; Updated: 05/14/01)

Course Objectives: Caring is not specifically identified in course objectives. The closest terms to caring are found in: Nurs. 327 - “theories of interpersonal communication and information technology are explored”; Nurs 332 – “compassionate and coordinated care”; Nurs 333 – “Emphasis is placed on the patient and/or designee as the source of control and full partner in providing compassionate and coordinated care”(Bachelor of Science in Nursing Current Course Offerings).

Saint Louis College of Nursing

Philosophy: Learning through a nursing procedure integrates with a caring theory inspired students to” (Bachelor of Nursing Science Philosophy, 2008)

Conceptual Framework: “The integration of nursing theories and especially caring theories are integrated in teaching-learning throughout out the curriculum.” (B.N.S Conceptual Framework, 2008)

Undergraduate Program Objectives: “To use nursing process with caring, ethical & moral behavior“ (B.N.S Curriculum Objectives, 2008)

Course Descriptions: “Basic Concepts in Nursing:... “Holistic nursing concepts; nursing theories; and related health care theories in caring within the scope of nursing profession;...” (B.N.S Course Descriptions, 2008).

“Fundamentals of Nursing: ...Providing holistic nursing to all individuals well and sick using nursing theories and caring concepts...” (B.N.S Course Descriptions, 2008)

APPENDIX J

E-MAIL CORRESPONDENCE WITH DEANS OF PARTICIPATING SCHOOLS

1. Southeastern School of Nursing

To: Dr. Marlaine Smith on August 5, 2011

Dear Dr. Smith:

This note is written with wishes that you have had a good summer. I am a long time nurse educator who is currently working on doctoral studies at the University of Kansas – School of Nursing and on my dissertation. Over the course of my study, I have become interested in caring patient relationships and the way in which our curriculums prepare students for establishing and maintain relationships in practice. I am writing to request your assistance in obtaining support for including baccalaureate nursing students (Beginning and senior level) from the Florida Atlantic University in my study

My dissertation focuses on the effects of baccalaureate nursing curriculums in preparing graduates to develop caring relationships with patients and families. The study aims to compare outcomes from nursing curriculums that integrate caring as a major concept with those that integrate systems as a major concept. I have not found studies that make such comparisons. Your school was recommended to me for inclusion by Jean Watson. Her Theory of Caring Science is being used for the theoretical foundation of the study. In addition, Madeline Leininger's perspective of care as a universal concept has provided interest in studying curriculums in both the U.S. and Thailand.

Measurement will be done through the administration of two questionnaires on caring (based on caring science and developed in part by Watson and Nelson) and a demographic questionnaire. Both questionnaires utilize a Likert Scale and can be completed within a brief time. The first questionnaire aims to measure students caring for self and is only 10 questions. The second questionnaire of 20 questions aims to measure student's perception of care provided to others. I anticipate that it would take student 15 minutes or less to answer the questions and the demographic sheet.

To meet power requirements for the study, I need 75 valid (all questions answered) questionnaires from students (seniors) who meet study criteria and who will graduate within the next academic year (2011-2012). In addition, I also need 75 students from the first year (the first quarter/semester of the year in which the first nursing course is taken) to complete the questionnaires. I understand that this is the junior year for UK college Data from freshman students will provide a baseline for comparison.

I hope that you will be able to support having your students included in the study I am writing to request approval and guidance on how best to proceed with administration of the questionnaires to students in a manner that would provide the needed return. Dependent upon approval of the proposal by my committee, I anticipate that the questionnaires will be printed and ready for distribution in early Fall (September-October). Completion will be done by paper

pencil/pen If it would be assistive to obtain increased returns, I would travel to UF or, if you believe it would be possible to work with faculty contacts, this would be fine

Prior to that time, I know that IRB procedures will need to be followed I will have completed the IRB process at the University of Kansas where I am completing the doctorate; and will have obtained institutional approval.

I will follow up with a telephone call to your Secretary in the near future to see if there is a time that we might further discuss the information included in this note. I am most appreciative of whatever assistance you can provide to my study!!! Wishes for a great new academic year! I have to say that I was impressed with your website and the materials that I read at that site!

Sincerely,

Connie Stopper
Doctoral Student
University of Kansas

Affirmative Response from Dr. Marlaine Smith

“I am forwarding your email to Dr. Sharon Dormire, the Assistant Dean for Undergraduate Studies. Sharon can assist you in the access you are requesting.”

2. Thailand School of Nursing

To Dr. Boonyanurak on July 19, 2011

Dear Dr. Boonyanurak:

This note is a follow-up to a recent e-mail from Ratchneewan Ross regarding my request for your assistance with my dissertation. I am currently completing my doctorate at the University of Kansas. My dissertation focuses on the effects of baccalaureate nursing curriculum in preparing graduates to develop caring relationships with patients and families. The study aims to compare outcomes from nursing curriculums that integrate caring as a major concept and those that integrate systems as a major concept. I have not found studies that make such comparisons Jean Watson's Caring Science is being used for the theoretical foundation of the study. In addition, Madeline Leininger's perspective of care as a universal concept has provided interest in studying curriculums in both the U.S. and Thailand.

First, I want to thank you for the curricular materials received early that describe Saint Louis College. I enjoyed reading the information and am impressed with the integration of caring and holism in the curriculum It contributed to my enthusiasm for the study.

Measurement will be done through the administration of two questionnaires on caring (based on caring science and developed in part by Watson and Nelson) and a demographic questionnaire. Both questionnaires utilize a Likert Scale and can be completed within a brief time. The first questionnaire aims to measure students caring for self and is only 10 questions. The second questionnaire of 20 questions aims to measure student's perception of care provided to others. I anticipate that it would take student 15 minutes or less to answer the questions and the demographic sheet.

To meet power requirements for the study, I need 75 valid (all questions answered) questionnaires from students (seniors) who will graduate within the next academic year (2011-2012). In addition, I also need 75 students from the first year (the first quarter/semester of the year in which the first nursing course is taken) to complete the questionnaires. I understand that this is the freshman year for your college Data from freshman students will provide a baseline for comparison.

It is my understanding that you are willing to have nursing students in the Saint Louis nursing program participate in the study. This note is to request guidance on how best to proceed with administration of the questionnaires to students in a manner that would provide the needed return. Dependent upon approval of the proposal by my committee, I anticipate that the questionnaires will be printed and ready for distribution in early Fall (September-October). Completion will be done by paper pencil/pen.

Prior to that time, I know that IRB procedures will need to be followed I will have completed the IRB process at the University of Kansas where I am completing the doctorate; and will have obtained institutional approval. I could send a copy of this approval if it would be helpful.

Please advise how to proceed through the IRB process at Saint Louis and what procedures to follow for administration of questionnaires to seniors and beginning level students. I am most appreciative of whatever assistance you can provide to my study!!!

Connie Stopper
Doctoral Student
University of Kansas – School of Nursing

Affirmative response to Dr. Ross following a follow-up inquiry from me regarding participation. “Connie Stopper is most welcome to directly contact me anytime and please apologize to her for me for the late publishing manuscript.”

3. Midwestern – School of Nursing

To: Dr. Karen Miller on August 3, 2011

Dear Dr. Miller:

This note is written with wishes that you have had a good summer. I am currently a doctoral student at the University of Kansas – School of Nursing and working on my dissertation with Drs. Helen Connors and Sue Popkess-Vawter as co-chairs. I am writing to request your assistance in obtaining support for including baccalaureate nursing students (Beginning and senior level) from the University of Kansas in my study.

My dissertation focuses on the effects of baccalaureate nursing curriculums in preparing graduates to develop caring relationships with patients and families. The study aims to compare outcomes from nursing curriculums that integrate caring as a major concept with those that integrate systems as a major concept. I have not found studies that make such comparisons. Jean Watson's Caring Science is being used for the theoretical foundation of the study. In addition, Madeline Leininger's perspective of care as a universal concept has provided interest in studying curriculums in both the U.S. and Thailand.

Measurement will be done through the administration of two questionnaires on caring (based on caring science and developed in part by Watson and Nelson) and a demographic questionnaire. Both questionnaires utilize a Likert Scale and can be completed within a brief time. The first questionnaire aims to measure students caring for self and is only 10 questions. The second questionnaire of 20 questions aims to measure student's perception of care provided to others. I anticipate that it would take student 15 minutes or less to answer the questions and the demographic sheet.

To meet power requirements for the study, I need 75 valid (all questions answered) questionnaires from students (seniors) who meet study criteria and who will graduate within the next academic year (2011-2012). In addition, I also need 75 students from the first year (the first quarter/semester of the year in which the first nursing course is taken) to complete the questionnaires. I understand that this is the junior year for UK college. Data from freshman students will provide a baseline for comparison.

If you are able to support the study, I request guidance on how best to proceed with administration of the questionnaires to students in a manner that would provide the needed return. Dependent upon approval of the proposal by my committee, I anticipate that the questionnaires will be printed and ready for distribution in early Fall (September-October). Completion will be done by paper pencil/pen. If it would be assistive to obtain increased returns, I would travel to UK ; Or, if you believe it would be possible to work with faculty contacts, this would be fine.

Prior to that time, I know that IRB procedures will need to be followed. I will have completed the IRB process at the University of Kansas where I am completing the doctorate; and will have obtained institutional approval.

I will follow up with a telephone call to your Secretary in the near future to see if there is a time that we might further discuss the information included in this note. I am most appreciative

of whatever assistance you can provide to my study!!! Wishes for a great new academic year!
The nursing program at UK has been a wonderful experience!

Sincerely,

Connie Stopper

Affirmative Response from Donna Claussen on August 8, 2011

“This response is on behalf of Dr. Karen Miller, Dean of the University of Kansas School of Nursing. Regarding your request for participation in your dissertation research, Dr. Miller asked me to share with you that all looks well on a precursory first pass. She asked that your request be further reviewed by our Associate Dean for Research and Associate Dean for Undergraduate Academic Affairs in the KU School of Nursing.”

Follow-up e-mail response to my note to Drs. Nelda Godfrey and Marge Bott.

“Hello, this is Nelda Godfrey, and I will be happy to help you with your study Dr. Bott and I have discussed your proposal, and I believe I will be able to help you sufficiently.”

APPENDIX K

STUDENT INFORMATION LETTER (ENGLISH VERSION)

Dear Nursing Student:

This letter is written to inform you about an opportunity to participate in a research study on caring in nursing education. I am a doctoral candidate working under the guidance of Dr. Connors and Dr. Popkess-Vawter at the University of Kansas. As a nurse educator, I am interested in understanding the relationship of your nursing curriculum to nursing student's perceptions of caring. Your participation is very important to the study! In order to conduct the study, beginning level and senior level nursing students are being recruited to answer three short questionnaires (CFS-CPV and CFS-CS) and a demographic questionnaire that is anticipated to take around 20 minutes to complete.

The Caring Factor Survey contains 20 short questions and the Care for Self Survey contains 10 questions requiring you to fill in a circle on a Likert Scale that indicates your choice of answers. Your response indicates your perceptions about the topic. There is no right or wrong answers. Participation is optional and you have the right to withdraw at any time. The questionnaire is anonymous and student names are not to be written on the questionnaires. Your completed questionnaires are to be placed in the box that will be provided by the proctor who will then mail them to my attention. Completion of the questionnaires provides agreement to participate in the study. Questionnaires will be retained in a locked file at the residence of the researcher.

Participation or non-participation does not affect your grades in the nursing program. Questionnaires will be sent directly to the researcher and will not be available to nursing program personnel. Individual student responses will not be identifiable. Upon request to the

researcher, your school may receive data to be used for program evaluation. Information provided to the school for program evaluation will not contain identifiable student information.

If you are interested in the results of the study, feel free to e-mail me at cstopper@kent.edu.

If at any time you have questions, concerns, or comments about the questionnaires, the study or study procedures feel free to contact myself or my advisors, Dr. Helen Connors (hconnors@kumc.edu) or Dr. Sue Popkess Vawter (spopkess@kumc.edu)

Sincerely,

Connie Stopper, RN, MSN, MEd., CNS

University of Kansas – School of Nursing

APPENDIX L

STUDENT INFORMATION LETTER (THAI VERSION)

โครงการวิจัยการรับรู้ในดูแลและให้การพยาบาลของนักศึกษาพยาบาล

สวัสดีค่ะนักศึกษาพยาบาลทุกท่าน

ดิฉันชื่อ คอนนี่ สต๊อปเปอร์ (Connie Stopper) เป็นวิทยากรพยาบาลที่กำลังศึกษาระดับปริญญาเอก (Ph.D. Candidate) ณ มหาวิทยาลัยแคนซัส (University of Kansas, USA) ซึ่งมี ดร. คอนเนอร์ส (Connors) และ ดร. ป็อบเคส-วอร์เทอร์ (Popkess-Vawter) เป็นอาจารย์ที่ปรึกษา ดิฉันมีความสนใจเกี่ยวกับความสัมพันธ์ระหว่างหลักสูตรการพยาบาลกับการรับรู้ในการให้การพยาบาลของนักศึกษาพยาบาลทั้งในประเทศไทยและสหรัฐอเมริกา การเข้ามามีส่วนร่วมในโครงการศึกษาวิจัยครั้งนี้ของท่านจึงมีความสำคัญเป็นอย่างยิ่งต่อระบบการศึกษาระดับบัณฑิตศึกษาพยาบาลในอนาคต

ผู้เข้าร่วมโครงการฯ ประกอบด้วย นักศึกษาชั้นปีที่ 1 ปีที่ 3 และปีที่ 4 จาก 3 สถาบัน ได้แก่ วิทยาลัยเซนต์หลุยส์ ประเทศไทย วิทยาลัยนอร์ทเท็นทรัลฟลอริดา (North Central Florida) และคณะพยาบาลศาสตร์ มหาวิทยาลัยแคนซัส (University of Kansas) โดยนักศึกษาทั้ง 3 ชั้นปีจาก 3 สถาบันจะทำการตอบแบบสำรวจสั้นๆ จำนวน 3 ชุด ซึ่งใช้เวลาทั้งหมดประมาณ 20 นาที แบบสำรวจชุดที่ 1 ได้แก่ แบบสำรวจปัจจัยการดูแลผู้ป่วยของผู้ให้บริการพยาบาล (CFS-CPV) ประกอบด้วย 20 คำถาม ชุดที่ 2 แบบสำรวจปัจจัยการดูแลตนเอง (CFS-CS) จำนวน 10 คำถาม และชุดที่ 3 แบบสอบถามข้อมูลทั่วไป ทั้งนี้แบบสำรวจชุดที่ 1 และชุดที่ 2 เป็นคำถามแบบตรวจสอบรายการตามมาตรวัดแบบลิเคิร์ต (Likert Scale) 7 ระดับ กล่าวคือ ไม่เห็นด้วยอย่างยิ่ง มีค่าเท่ากับ 1 เห็นด้วยอย่างยิ่ง เท่ากับ 7 เป็นต้น

การตอบแบบสำรวจชุดที่ 1 และชุดที่ 2 นั้นให้ท่านเลือกวงตัวเลขได้ข้อความแต่ละข้อที่ตรงกับความคิดเห็นของท่านเองมากที่สุด คำตอบของท่านจะเป็นตัวบ่งชี้ค่าการรับรู้ของท่านต่อประเด็นนั้นๆ คำตอบของท่านไม่มีถูกหรือผิด ท่านมีสิทธิ์ที่จะถอนตัวออกจากโครงการฯ เมื่อใดก็ได้ และการเข้าร่วมโครงการฯ ครั้งนี้เป็นแบบนิรนาม ท่านจึงไม่ต้องระบุชื่อของท่านลงบนแบบสำรวจแต่อย่างใด ท่านที่ทำแบบสำรวจครบถ้วนหมายความว่าท่านได้เข้าร่วมโครงการวิจัยนี้แล้ว เมื่อตอบแบบสำรวจเสร็จแล้ว กรุณาวางแบบสำรวจที่ตอบเรียบร้อยแล้วลงในกล่องที่จัดวางไว้ให้ ทั้งนี้ผู้ประสานงานจะส่งแบบสำรวจทั้งหมดถึงตัวผู้วิจัยเอง และแบบสำรวจทั้งหมดจะถูกเก็บไว้ในตู้เอกสารที่ปิดล็อกอย่างปลอดภัย

การเข้าร่วมหรือไม่เข้าร่วมโครงการฯ ในครั้งนี้ จะไม่มีผลกระทบต่อผลการเรียนของท่านแต่ประการใด แบบสำรวจของท่านจะถูกส่งไปยังผู้วิจัยโดยตรง และไม่ผ่านคณาจารย์ในสถาบันการศึกษาของท่าน ไม่มีคณาจารย์ท่านใดจะได้เห็นแบบสำรวจของท่าน คำตอบของท่านจะถูกประมวลผลเป็นรายกลุ่ม และจะนำเสนอในภาพรวมเท่านั้น สถาบันการศึกษาของท่านอาจจะขอทราบผลการศึกษาวิจัยเพื่อใช้ในการประเมินและปรับปรุงหลักสูตรฯ ดังนั้นข้อมูลที่ทางสถาบันการศึกษาจะได้รับจะเป็นผลการวิเคราะห์ในภาพรวมเท่านั้น ผลผลดังกล่าวจะไม่ระบุชื่อหรือรายละเอียดส่วนตัวของนักศึกษาผู้ตอบแบบสำรวจแต่อย่างใด หากท่านประสงค์ต้องการทราบผลการศึกษาวิจัย กรุณาอีเมลถึงดิฉันซึ่งเป็นผู้วิจัยได้โดยตรงที่ cstopper6@aol.com

หากมีข้อสงสัย ข้อชี้แนะเกี่ยวกับโครงการวิจัย กระบวนการวิจัย และแบบสำรวจการวิจัยในครั้งนี้ สามารถซักถามได้ที่ดิฉัน หรือติดต่อโดยตรงไปที่อาจารย์ที่ปรึกษาของดิฉัน ซึ่งได้แก่ ดร. เฮเลน คอนเนอร์ส (Helen Connors) ที่อีเมลล์ hconnors@kumc.edu หรือ ดร. ซู ป็อบเคส-วอร์เทอร์ (Sue Popkess-Vawter) ที่อีเมลล์ spopkess@kumc.edu

ขอขอบคุณทุกท่านเป็นอย่างยิ่งที่ให้ความร่วมมือตอบแบบสำรวจในครั้งนี้

ขอแสดงความนับถือ

คอนนี่ สต๊อปเปอร์

(รองศาสตราจารย์ Connie Stopper)

RN, MSN, MEd, CNS, Associate Professor

University of Kansas – School of Nursing

อีเมลล์ cstopper6@aol.com
โทรศัพท์ 001-1-330-524-4490

APPENDIX M

FOLLOW-UP LETTER TO SCHOOL CONTACT PERSONS

Dear (Name of Contact Person)

Thank you for your agreement to assist in collection of data for my dissertation focusing on comparing nursing curriculums that have caring as the primary concept of focus with systems as the primary concept. To identify curriculum effects, student perceptions of their care for patients and care for self are being measured. Senior level nursing students are requested to complete a questionnaire reflecting care of patients (20 questions) and a questionnaire reflecting care of self (10 questions) using a Likert Scale. In addition, completion of a demographic questionnaire is requested. The same questionnaires are being collected from beginning level nursing students to provide baseline data.

Enclosed with this letter is the following:

1. Directions for distribution of student questionnaires.
2. A packet of materials for each student, senior (100), junior level (100), and freshmen level (100) for Thai students only. The packets contain a cover letter for the student, the two caring questionnaires, and a demographic questionnaire..
3. Extra pencils for students who may not have a pen or pencil with them at the time of distribution.
4. An envelope marked for undistributed questionnaires.
5. A pre-paid, addressed U.S. Post Office box for returning any questionnaires that were distributed to students and returned to you completed or not completed.

In order to meet power requirements for the study, 75 completed questionnaires for each level, beginning and senior, are required, as well as an additional 75 questionnaires for freshmen

in the Thai sample. A total of 100 packets for each of the study groups have been included to maximize reaching the required numbers of valid questionnaires.

Please distribute a questionnaire to each student at the time of announcing the study. If you have more questionnaires than students, please put the extra questionnaires in the envelope provided and marked as 'Undistributed Packets'. Students may return their questionnaires (whether completed or not completed) to the box provided with the materials being sent to you. After all questionnaires have been received, please seal and place the box in the mail. Enclose the envelope of 'Undistributed Packets' in the box before sealing and mailing it.

Once again, I appreciate your efforts in obtaining participation of students in the program and coordinating the data collection within your school. If there are any questions, feel free to contact me by e-mail (cstopper6@aol.com) or by phone (cell: 330-524-4490 or office: 330-569-6186). Feel free also to contact my advisors: Dr. Helen Connors by e-mail (hconnors@kumc.edu) or office phone (913-588-1614) or Dr. Sue Popkess-Vawter by e-mail (spopkess@kumc.edu) or office phone (913-588-3373).

APPENDIX N

GUIDELINES FOR DISTRIBUTION OF STUDY QUESTIONNAIRES (ENGLISH VERSION)

- Distribute a student packet to each student. A student packet contains two questionnaires (CFS-CPV and the CFS-CS), a demographic questionnaire, and a student information sheet.
- Advise the student that the information that they provide is very important to the study aimed at understanding the inclusion of the concept of caring in their curriculum.
- Inform students that completion of the questionnaires is anticipated to take less than 20 minutes to complete.
- Announce that:
 - Participation in the study is optional and that completion of the questionnaire gives consent to participate.
 - Students are not to mark their names on the questionnaires so that student responses cannot be connected to any individual student.
 - Students who elect not to complete the questionnaire, as well as those who do complete the questionnaire are to return their packet to the envelope provided.
 - Students are to respond to each and every question to the best of their ability
Explain how important it is that all questions are answered and that no questions are left blank.
- Advise that students may contact Dr. Helen Connors, Dr. Sue Popkess-Vawter, or Connie Stopper with any follow-up questions, concerns, or other information.

APPENDIX O

HUMAN SUBJECTS APPROVAL FOR EXEMPT STATU

The University of Kansas Medical Center

Human Research Protection Program

December 30, 2011

Project Number:	13024
Project Title:	Perceptions of Caring by Senior Level Baccalaureate Nursing Students from Thailand and the United States as Influenced by Curriculum Focus: A Descriptive Exploratory Study
Sponsor:	None
Protocol Number:	N/A
Primary Investigator:	Helen Connors, Ph.D.
Department:	Administration - School of Nursing
Meeting Date:	12/20/2011
HSC Approval Date:	12/29/2011
Type of Approval:	Exempt b (1)

Dear Investigator:

This is to certify that your research proposal involving human subject participants has been reviewed and **approved** by the KUMC Human Subjects Committee (HSC). This "exempt" approval is based upon the assurance that you will notify the HSC prior to implementing any revisions to the project. The HSC must determine whether or not the revisions impact the risks to human subjects, thus affecting the project's "exempt" status. Projects that do not meet the "exempt" criteria must comply with all federal regulations regarding research.

If you have any questions regarding the human subject protection process, please do not hesitate to contact our office.

Very truly yours,



Daniel J. Voss, M.S., J.D.
IRB Administrator